Sea&Shore

THE NAVY AND MARINE CORPS AFLOAT AND SHORE SAFETY MAGAZINE

WHERE ARE THE SAFETY OFFICERS?

LEARN MORE ON PAGE 2

2017 Vol. 13 | No. 1

Sea&Shore

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MESSAGE FROM THE EDITOR

In spring of 2017 the Naval Safety Center converted all of its publications to an online format due to budget constraints. Since that transition, you the reader have supported the move, but made clear of the difficulties associated with having an online and downloadable only series of publications. The leadership of the Naval Safety Center has heard those concerns and as change is the one constant that we can always count on, decided to revive the printing of our publications.

Sea & Shore magazine remains a comprehensive source of information for managing risk, reducing the potential for error, and improving overall performance within the fleet. The magazine will not change and will still include articles about best practices, lessons learned, technological advances, research and development, future initiatives, new ideas, personal experiences, and risk-and-resource management strategies.

The magazine will be printed on a quarterly basis and all the articles will be individually posted to the 360° Safe blogsite for ease of reading and access online. A PDF version of Sea & Shore magazine will also be posted to the 360° Safe blogsite and DVIDS site for those who would like to read the magazine in that particular format. Distribution of our publications will be subscription-based and we ask that all those who would like to continue receiving a particular publication, complete a new subscription request and return it to our staff by mail, fax, or email. Thank you to all of our loyal readers, it's good to be back in print!

Editor Sea & Shore Magazine

CONTRIBUTORS WANTED

We do our best to cover stories, articles and information that may be helpful or necessary to manage your safety program and/or promote safety awareness on and off duty. We want to hear from you; we want you to write about your safety programs, best practices, and your on or off-duty risk-management stories.

Article Formatting
Articles should be sent in a Microsoft Word document format.
FONT: Courier New
SPACING: Double spaced (1 space after period)
FONT SIZE: 12 point
NECESSARY INFO: Include a proposed headline, the full byline of the author (rank, first, and last name), the authors unit, and job title.
** If possible, please submit a 300 dpi head & shoulder jpeg image of the author to be printed with the submitted article.*

Article Lengths
Short story: 800-1,500 words
Feature story: 2,500-3000 words
News briefs: 500 words
** The word count is meant to be used as a reference point for the length of a story or news brief.*

Fact-checking
We ask that writers research reference materials used in their articles for accuracy. Please verify your sources before attributing quotes to them. If you need us to perform additional fact-checking, please make a note of it when submitting your article.

Photo Guidelines
All photos must be high resolution (300 dpi) in JPEG format. Photos submitted in a word document or PDF will lose it's quality, therefore we prefer the raw file. Be sure to include the photographers full name, rank and service. If you have an image larger than 10MB, email us first for an alternate submission process.

Our surveys consistently show that readers like articles written by their peers, and they like to read about true-life events and experiences. Your effort keeps others from having to learn the hard way. Therefore we want your letters, feedback, and comments.

We want honest appraisals and realistic solutions. Our staff is always open to new ideas, so don't be afraid to try something different. Send your submissions, and comments to michael.j.morris@navy.mil.

WHERE ARE THE SAFETY OFFICERS?

By Joe Perfetto

Mr. Perfetto works in the Shore Safety Programs Directorate at the Naval Safety Center, where he serves as a safety and occupational health specialist.

This question is being asked more often than not: Where are the safety officers, managers, specialists and collateral duty safety officers? As safety officers, managers, specialists and collateral duty safety officers, do you have direct access to the commanding officer or officer in charge to inform him or her of potential safety issues that are a concern to the command?

During safety assessments conducted by Naval Safety Center analysts, they ask safety professionals the following questions: Where are you in the chain of command? Do you have direct access to the commanding officer or officer in charge? The answers vary, but the bottom line is that there are safety officers, managers, specialists and collateral duty safety officers who lack access to the commanding officer or officer in charge.

According to Navy policy OPNAVINST 5100.23G:

0302: Organization of Safety Organizations at Headquarters Commands

Headquarters commands shall designate a safety official who will have sufficient authority and responsibility to represent effectively and support the headquarters commander in the management and administration of the headquarters command safety program. The designated safety official shall report directly to the headquarters commander. A safety organization, staffed and organized commensurate with the mission and functions of the command, shall support and report directly to the designated safety official. A safety professional shall head the safety organization. Professional certification is recommended, per paragraphs 0304.c and 0606.

0303: Organization, Functional Responsibilities, and Staffing Criteria for Shore Safety

a. Organization.

(1) Each shore activity not receiving base operating (BOS) safety services from their cognizant naval region shall have a safety organization, staffed and organized commensurate with the mission and functions of the command. A safety professional shall head the safety organization and shall have the authority, responsibility, and visibility to manage and represent effectively the activity's safety program. Implementation of the safety program is considered a command staff level function. Accordingly, the head of the safety organization shall report directly to the commanding officer of the shore activity.

In addition Paragraph 402 f.(1) reads:

If the region or activity safety manager attends routinely scheduled department head (staff) meetings or personally briefs the commanding officer/executive officer on a recurring basis, where safety items can be discussed in a timely manner, only one formal annual meeting is required. Otherwise, the council shall meet annually or more frequently as needed. The region or activity safety organization shall retain minutes on file for a minimum of three years.

If safety officers, managers, specialists and collateral duty safety officers are not reporting to the commanding officer or officer in charge, does it infer that safety is no longer important? If safety professionals are buried behind the operations officer, aviation safety officer or other individuals, is safety becoming a secondary concern? If safety professionals do not have access to the commanding officer or officer in charge, are there safety concerns that they should be aware of and are not?

SCENARIO

The safety professional identifies a safety concern or trend that he or she feels the commanding officer or officer in charge should be aware of, but does not have direct access to the commanding officer or officer in charge. He or she must go through the chain of command to get this information to them. What if the message gets modified or someone in the chain of command does not think the information is important enough to bother the commanding officer or officer in charge? What happens if someone is injured or a fatality occurs that could have been prevented? What then?

We understand that commanding officers and officers in charge are busy. Safety officers, managers, specialists and collateral duty safety officers should be trained to handle safety issues and concerns. They should also have the training and the authority to handle all safety concerns without having to inform the chain of command in advance. It is concerning, if the safety professional does not have this authority or must go through a number of individuals to inform the commanding officers and officers in charge of a potential safety issue.

Safety should be part of the command culture and climate. The safety professional should be involved with every aspect of the command. Commanding officers or officer in charge should listen to their safety professionals.

In turn safety professionals, supervisors, and employees should have the authority to stop any activity that could potentially cause an injury. The Naval Safety Center does not receive reports of safety professionals that temporarily stop a process to ensure safety protocol is being adhered to or cases where safety measures are absent from the process and safety is incorporated on-the-spot with the process proceeding without incident. We know this happens and the question to the commanding officer and officer in charge is, "Do you know the condition of your safety program?"

WORKPLACE SAFETY... WE'RE ALL IN THIS TOGETHER

DO IT FOR YOURSELF, YOUR FAMILY AND YOUR CO-WORKERS

STAY AWARE —
keep up-to-date on all posted safety rules and regulations

FOLLOW THE RULES —
put the rules and regulations to use every day

REPORT —
if you see any hazards, incidents and near misses

WORK SMART —
report any work-induced discomfort early

STEPS TO SAFETY —
start with using the handrails in the stairways

HANDLE WITH CARE —
when lifting and carrying materials

FOCUS —
on the task you're doing, driving, walking and working

Safety is a team "sport." It's time we step up and commit to a culture of safety, where we can do our jobs knowing that we're all doing what we have to do to prevent accidents, injuries and sometimes even worse in the workplace. The time is now for us all to come out winners.

Preventable injuries are now the fourth leading cause of death in the United States behind heart disease, cancer and chronic respiratory disease.

SOURCE: *Injury Facts® 2016 Edition*

For more information on this and other safety topics, please log on to the member-exclusive website at **nsc.org**.

NATIONAL SAFETY COUNCIL®
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FOOD SAFETY AT HOME

By HM2(SW/FMF) Bradley Proctor

HM2(SW/FMF) Bradley Proctor serves as a preventive medicine technician aboard the USS Kearsarge (LHD 3).

Even though the food supply in the United States is one of the safest in the world, the Centers for Disease Control and Prevention estimates that each year roughly one in six Americans gets sick, 128,000 are hospitalized and 3,000 die of foodborne illnesses. While restaurants and grocery stores are heavily regulated on food safety, individuals are often either uneducated or apathetic toward preparing and storing food safely at home. The Orange County Health Agency in California has identified the five leading causes of foodborne illness: Improper hot/cold holding temperatures of potentially hazardous food, improper cooking temperatures of food, dirty and/or contaminated utensils and equipment, poor health and hygiene, and receiving food from unsafe sources.

The presence of one or more of these risk factors poses a substantial hazard to anyone, especially populations at increased risk such as the elderly, young children or the already sick. In the following paragraphs, I will discuss how you can prevent these risk factors and save yourself and yours from having to endure a foodborne illness.

Most people have some type of refrigerator, but not everyone knows how to safely store food in it. According to NAVMED p-5010-1, potentially hazardous food such as cooked or raw meat or cooked grains, fruits, or vegetables must be stored either below 41 degrees Fahrenheit or above 135 degrees Fahrenheit; these temperatures are shown to slow the growth of microorganisms that cause illness. When defrosting meats, move the item from the freezer to the refrigerator, allowing it to thaw without being out of the proper cold-holding temperature. Hot food must be kept above 135 degrees Fahrenheit until ready to serve.

When it comes to cooking safely, never "eyeball" how thoroughly something is cooked. Food must be cooked to an internal temperature of 165 degrees Fahrenheit for 15 seconds, which can be measured with a probe thermometer. The temperature must be taken in the thickest part of the meat, taking care to not penetrate all the way to the cooking surface. Cooking food to the correct temperature is the only way to actually destroy illness-causing bacteria.

When utensils or equipment become dirty or contaminated, they can transfer that contamination to the food, which then can cause foodborne illnesses. Utensils can be contaminated with a buildup of food residue that creates a breeding ground for bacteria; cross contamination can also occur from coming into contact with either raw and ready-to-eat food, or toxic chemicals. Any surface that contacts food must be regularly cleaned as to avoid build-up of food residue. Anytime raw food touches the surface of a utensil or equipment, that surface should only to be used for that food until being thoroughly cleaned. Utensils and equipment can easily transfer bacteria from raw foods to ready-to-eat foods if you do not strictly adhere to this concept. Be sure to keep household cleaning products in a separate area from anything that comes into contact with food. If you suspect poisoning, you should immediately contact your local poison control center.

The importance of hand washing cannot be understated. Proper handwashing prevents the bacteria from everything you have touched around the house from entering your food. Regular handwashing will prevent cross contamination between different foods. Proper handwashing should consist of using warm water and soap for a minimum of 10 to 15 seconds to ensure bacteria is removed; you should also cover any cuts or open wounds on your hands while handling food.

Remember to always purchase food from a reputable source, where food is properly handled to avoid the aforementioned hazards. Look for U.S. Department of Agriculture (USDA) or Food and Drug Administration (FDA) stamps on food items. Raw food should be received below 41 degrees Fahrenheit and hot food above 135 degrees Fahrenheit.

Adherence to food safety rules is an easy way to ensure the health of you and your family. Foodborne illnesses have a significant time and monetary impact on both business and the individual; in labor and medical costs. The USDA estimates that foodborne illnesses cost Americans $15.6 billion each year. Be smart, reduce risk, and protect those around you.

ONLINE RESOURCES

Centers for Disease Control and Prevention

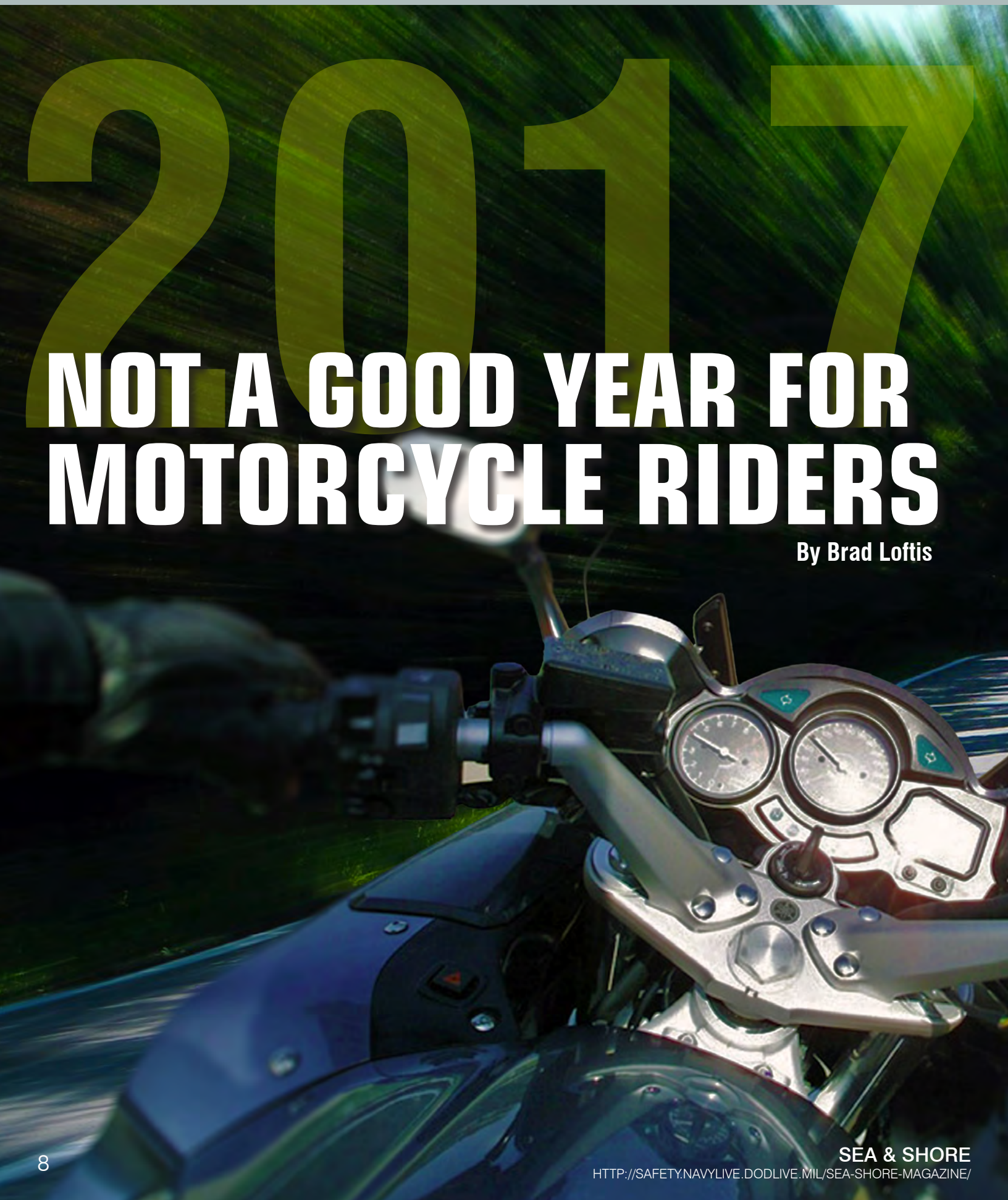
▶https://www.cdc.gov/foodsafety/cdc-and-food-safety.html

Orange County Health Care Agency

▶http://www.ocfoodinfo.com/illness/risk

Navy Medicine

▶www.med.navy.mil/directives/Pub/5010-1.pdf



2017 NOT A GOOD YEAR FOR MOTORCYCLE RIDERS

By Brad Loftis

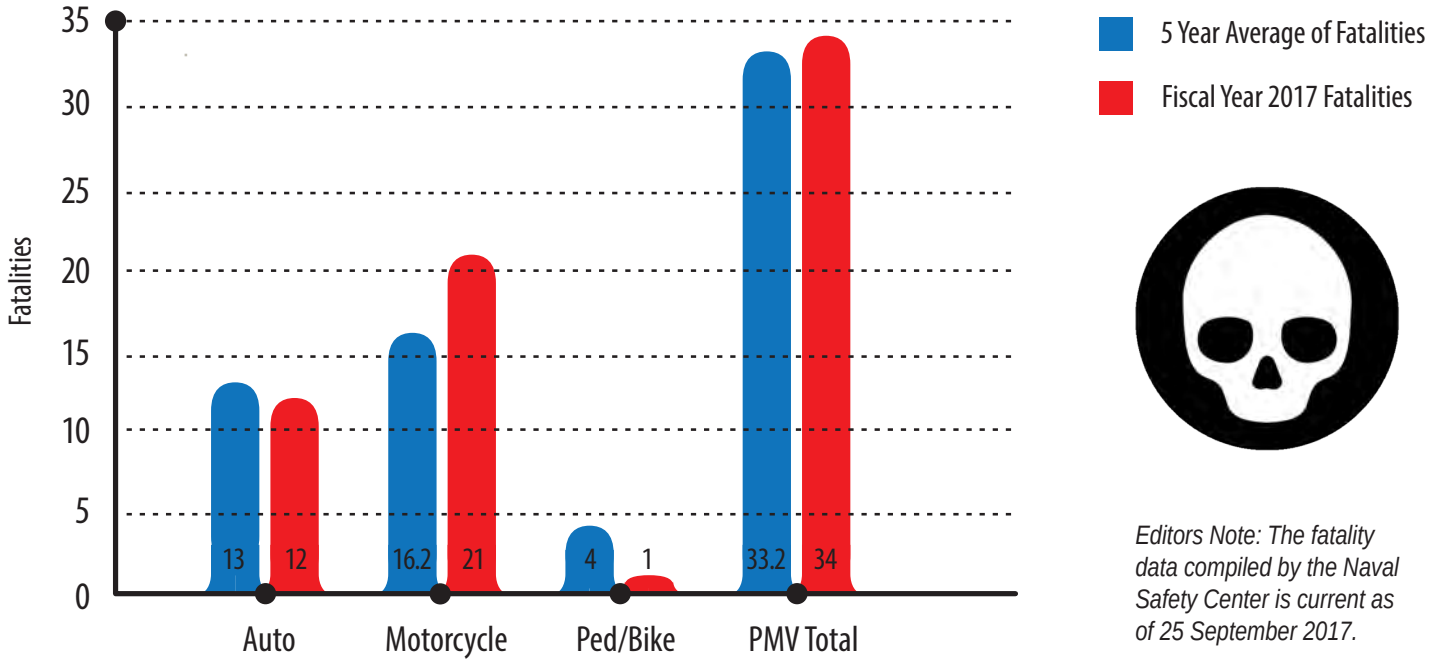
Motorcycle fatalities for the Navy in fiscal year 2017 exceeded the number of fatalities from both fiscal years 2015 and 2016. Even though fiscal years 2015 and 2016 were historically low years with 12 fatalities each, does not mean we should accept an upward trend back to the 10-year average of 17.6 fatalities. Our goal should always be the reduction of the fatality rate each year.

Brad Loftis works in the Shore Safety Programs Directorate at the Naval Safety Center, where he serves as the traffic and recreational off-duty safety division head.

According to Naval Safety Center data, more personnel are lost per year in personal motor vehicle (PMV) mishaps than in any other type of fatality. To combat this and help stop this negative trend, the Safety Center is aggressively raising awareness. Our safety promotion strategy includes yearly safety campaigns, articles in our safety magazines, and weekly "Rider Down" reports. Our subject-matter experts are more focused on conducting in-depth ongoing mishap analysis to identify trends and factors for dissemination up the chain and out to the Naval Enterprise. Additionally, since we switched from conducting safety surveys in 2015, we have been providing assessment teams to review command rider programs and pursuing a new motorcycle training program called REST (riders essential skills training). This new program will potentially provide training at more realistic speeds to simulate actual riding conditions and improve skill sets.

Leadership involvement is needed at the command level to ensure motorcycle riders and motorcycle safety representatives have the support and backing of the chain of command. Leaders at all levels should show interest and promote this vital safety program. Some items that can be done at the command level are as follows: start a mentorship program, inform new check-ins about the safety program, conduct group rides, coordinate a track day, advertise the program, and hold monthly meetings. Motorcycle riders need to ride by example, be good role models for other riders, wear all PPE, share experiences and encourage others to participate in the safety program.

NAVY PERSONAL MOTOR VEHICLE (PMV) FATALITIES FISCAL YEAR 2017



Editors Note: The fatality data compiled by the Naval Safety Center is current as of 25 September 2017.

ADDITIONAL RESOURCES

National Highway Traffic Safety Administration
▶ https://www.nhtsa.gov/road-safety/motorcycles

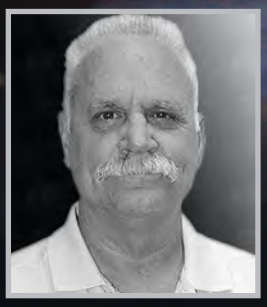
Motorcycle Safety Foundation
▶http://msf-usa.org/


TOUGH ON THE OUTSIDE.
SOFT AND SQUISHY ON THE INSIDE.
Share the Road
Share the road with motorcycles

THE DANGERS OF TEXTING WHILE DRIVING:

A PERSONAL PERSPECTIVE

By Michael Borkowski



Mr. Borkowski works in the Shore Safety Programs Directorate at the Naval Safety Center, where he serves as a traffic and recreation off-duty safety specialist.

As a former police officer and mishap investigator, I have witnessed first-hand death and carnage on our highways that no person should. Due to my experience, I have major concerns with poor choices such as texting while driving. Let's be honest, either you or someone you know has texted while driving at least once; a choice that has endangered you and those around.

Driving is a privilege — not a right — and it comes with personal responsibilities. Those responsibilities require undivided attention so that other drivers, pedestrians and cyclists who share the road with you are not placed in danger. One of the most alarming behaviors I see on a daily basis is the driver who cannot put their phone down, sending or receiving emails or texts. We've all seen them, drivers with one hand on the wheel the other hand clutching the cell phone like they have a winning lottery ticket. We should have little to no tolerance for individuals who text while driving and endanger those of us sharing the roadway with them.

A few years back I placed a magnetic message decal on the back of my truck tailgate that's in the shape of a yellow traffic warning sign with the words "Drive Now – Text Later" and the international symbol for no over a cell phone. When my 19-year-old daughter noticed the magnet, I got a verbal "really Dad?" and the look. It was at that time I made a standing bet with her that if she ever caught me using the phone while driving, I would put a brand new $50 bill in her hand.

Even as vehicles have become structurally safer and smarter than ever before, traffic deaths have risen over the past two years, reversing a general decline going back nearly a decade. According to the National Safety Council (NSC) 40,200 people died on the nation's roads last year. This number is up about 6 percent from 2015, when 35,092 died. The National Highway Safety Administration (NHTSA) shows that 3,477 of the people killed and 391,000 of people injured in motor vehicle crashes in 2015 involved distracted drivers.

Now, you may be one of those drivers who thinks you've got it all figured out. You're in control; you

haven't crashed yet, right? You've been using your cell phone and texting for some time now and have it mastered; you call it multitasking, right again? Wrong, removing your eyes from the road or hands from the wheel is in no way safe, no matter how you look at it. Texting is six times more likely to cause an accident than driving while intoxicated. The NHTSA reported that sending or reading a text message can take the driver's eyes off the road for an average of 4.6 seconds. At 55 mph, that's like driving the length of an entire football field with your eyes closed according to the Centers for Disease Control. Some drivers assume that taking your eyes off the road for close to five seconds is no big deal, but you can imagine the dangerous scenarios which could occur in that short window of time. The latest report issued in June 2017 by the Insurance Institute for Highway Safety (IIHS), shows that text messaging is currently banned for drivers in 47 states and the District of Columbia.

The use of cell phones while driving plays a role in 1.3 million crashes each year, causing 500,000 injuries and 6,000 deaths according to the U.S. Department of Transportation. Text messaging is the most dangerous practice, making a crash 23 times more likely. The NSC states that even if cell phone use in crashes was captured 100 percent of the time, the data would still be under-reported. National state and local organizations are taking steps to improve collection of crash data about driver cell phone use.

The Navy is also moving forward and taking steps to improve data collection in the Web Enabled Safety System (WESS) by using Human Factors Analysis and Classification System (HFACS). While HFACS doesn't specifically call out distracted driving as a separate precondition or act, a recent review of PMV4 fatal crash data identified preconditions such as "not paying attention" and "awareness" which can be indicative of distracted driving. Deeper analysis revealed driver acts that showed the driver either "drifted out of lane (not due to falling asleep) or "didn't keep eyes on the road" and "reacted too slowly;" all of these actions coincidently mirror the behavior of distracted drivers.

In a recent NSC driver safety poll, 74 percent of people polled rated distracted driving as a top concern, right behind drunk driving, which came in at 78 percent. Even though 74 percent of those polled agree that distracted driving is a top concern, one-third of drivers still reported sending a text message or email while driving at least once in the past 30 days and 42 percent stated that they had read a text or email. In the NSC driver safety poll, 53 percent of the respondents said they believed it is unsafe to text, use voice commands, or talk on a phone while driving.

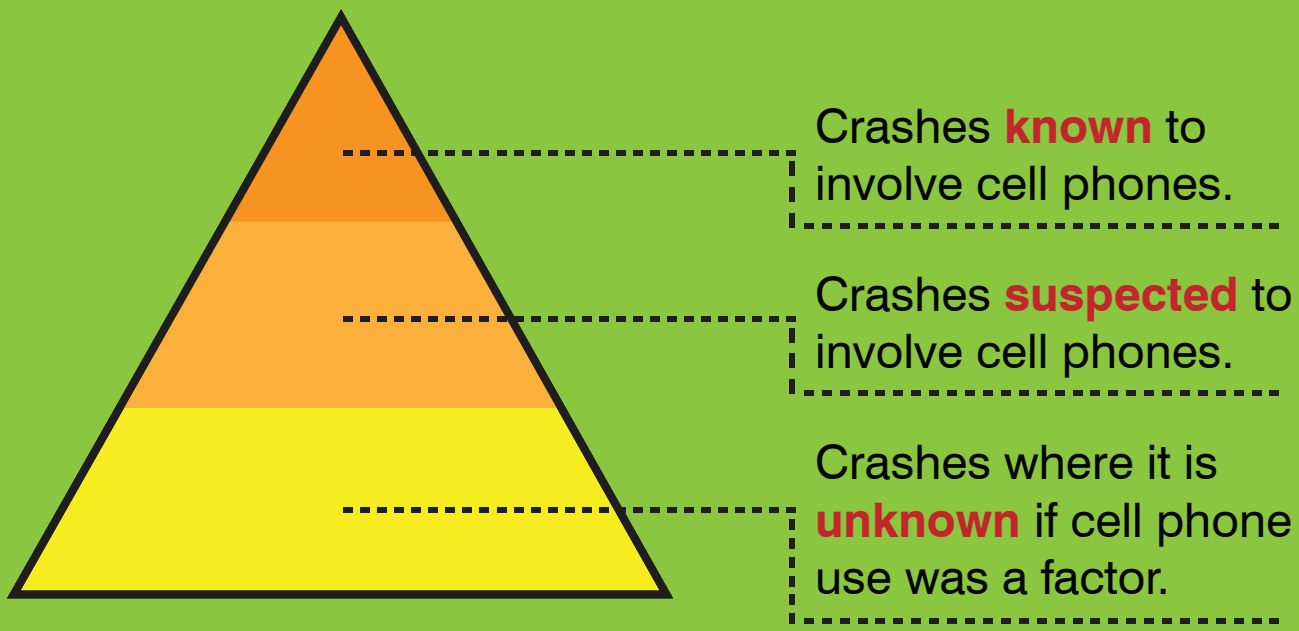
The problem in many cases is that what people say and what they do is totally different. Those of you that have attended one of my driver improvement courses may recall when I mentioned that it is humanly impossible to sneeze with your eyes open. I then asked, "How many of you have ever sneezed while driving?" A lot of hands went up. Then we had a reality check, at 60 mph your vehicle is traveling 90 feet per second (fps). During that one sneeze, you lost six car lengths without a clue as to what happened around you. Now remember, as previously mentioned, the average text message can take your eyes off the road long enough to cover a football field; an eye opener.

Not only do these poor choices endanger everybody on the road, but there are monetary costs associated to those choices. Because of the irresponsible drivers who text and drive, insurance policy prices have risen, increasing what policy owners pay for insurance across the board. According to the insurance industry, this rise in vehicular accidents has forced a 16 percent increase in rates since 2011. About 13 percent of drivers age 18 to 20 who were involved in car wrecks admitted to texting or talking on their mobile devices at the time of the crash.

Just as public opinion has made drunken driving socially unacceptable, public opinion could make texting and driving undesirable too. Those drivers who are texting while driving are easy to spot, because they demonstrate similar behaviors as those drivers under the influence of alcohol. They usually weave in their

The three levels of knowedge about cell phone crashes:

We do not know the exact number of crashes involve that drivers using cell phones, and it may not be possible to ascertain those statistics.



Even if 100% of known crashes were captured, data would still be greatly under-reported.

lane from one side to the other, travel slower than the surrounding traffic, leave huge gaps between them and the vehicles in front of them, and often show a delayed reaction time.

Unfortunately, with the ability to place the phone down or out of sight in an instant, the chances of getting caught by the authorities are slim. So most of the time the laws against texting and driving are almost impossible to enforce, unless the driver involved in a crash admits that they were texting or playing with their phone at the time of the incident. It can be challenging to verify that cell phone use was a contributing factor in an accident.

The truth is that almost every day there is a motor vehicle crash where use of the cell phone or texting was a contributing factor to the accident. Knowing this fact, I urge all drivers to put their phones down and drive responsibly. I hope that the distracted driving statistics in this article are enough to help make responsible driving your priority once you get behind the wheel. In this age of convenience and instant gratification it may seem that texting while driving is OK, but

it really isn't. Stop to consider the consequences. Is it worth it? Is there anything in life that can't wait to be taken care of later? Your life and the lives of others are certainly worth more than a scroll through Facebook, updating your page or a text message. Remember to make conscious responsible decisions once you get behind the wheel and don't let a crash or a ticket be your wake up call to put the phone down. When you're in the vehicle – put the phone down and let voice mail take your calls for you. You may be one of those people who may have to turn the phone off or place it out of reach. In the same way that we have made it a habit to buckle–up, you could try to make it a habit of using the center console or glove box to store your phone while driving. "Buckle-Up & Forget About It" could be your new motto.

A search of crash report news articles where cell phone use was captured are bulleted below:

- In March of this year in Texas, there was a fatal crash in which a driver who was texting crashed into a church bus, killing 13 people.
- A 19-year-old mother-to-be from Naples, Florida, was killed in a tragic car crash when she was hit by a driver using a cell phone to send text messages.
- A 20-year-old woman from Waynesburg, Pennsylvania, was sentenced to jail time after a crash in which her cell phone use caused her to collide with another vehicle. The driver of the other vehicle, a 16-year-old young lady, was killed in the crash. The driver in question was found to have been speeding and reaching for her cell phone at the time of the accident.
- An 18-year-old Minnesota resident was charged with gross negligence and vehicular homicide after a series of 15 text messages sent and received while driving resulted in the wrongful death of a 77-year-old woman. According to reports in the Fergus Falls Daily Journal, the teen hit the woman's vehicle in a head-on collision, sustaining serious injuries herself. She will serve up to 10 years in prison as a result of the crash.
- A 70-year-old man stepped out of his car to inspect possible damage after a minor fender-bender, only to be hit and killed by a distracted driver who was logged-in to Facebook at the time of the accident. Details of the accident suggest that the woman in question was updating her Facebook page via mobile phone.

IF IT'S AN EMERGENCY OR IT CANNOT WAIT, PULL OVER SAFELY AND HANDLE THE SITUATION.

I know I'm not going to get everyone on board here and there will always be someone who argues the point that there are enough laws already on the books to stop hazardous driving. They see anti-texting laws as the long arm of government reaching into their personal vehicles. That argument might make more sense if distracted drivers didn't also kill other innocent drivers and passengers.

The bottom-line is educating people about the dangers of distracted driving. We all need to be part of the solution, not the problem. Educate and encourage those in your inner circles to not use the cell phone while driving. The safety of everyone who uses our roadways depends upon safe driving practices and all drivers should act responsibly. Texting while driving is just simply not being responsible. The life we save may be our own or our children. The naval community ended the fiscal year with a total of 12 PMV4 traffic related deaths.

For those of you who read this to the end and were still wondering, my daughter has yet to collect that bet.

ONE TEAM, ONE FIGHT - DRIVE NOW, TEXT LATER

Drive Without Distractions

Give the road your full attention and arrive alive

Adjust your mirrors, seat, radio and air temperature **before you drive**

Don't reach down, behind your seat or pick up items from the floor **while driving**

Program the GPS, know your route and get traffic reports **before leaving**

Avoid eating and drinking **when you drive**

Do NOT talk on your cell phone or infotainment system **while on the road**

Pull over somewhere safe **to care for children**

THAT PHONE CONVERSATION CAN WAIT.

DRIVERS TALKING ON HANDHELD OR HANDS-FREE DEVICES CAN FAIL TO SEE 50% OF THEIR SURROUNDINGS.

MAN OVERBOARD INDICATOR

MOBI

Malfunctions & Testing

By LT Steven Scoville

LT Steven Scoville serves as the ground safety officer for Strike Fighter Squadron (VFA) 154.

Throughout April 2017, Carrier Air Wing (CVW) 11 was embarked on USS Nimitz (CVN 68) for Composite Training Unit Exercise (COMPTUEX) prior to our 2017 deployment. It was the last night of the exercise, so the air wing was doing a pack-out, which started much later than anticipated; causing everyone to feel rushed. Our team needed to get our entire squadron packed up and ready to debark from the ship in San Diego, California, early the next morning.

As we proceeded with the job at hand, a Sailor had confused a bag full of float coats for a bag of trash. Unfortunately, going against better judgment the Sailor had decided to throw the bag overboard, which meant that five of Strike Fighter Squadron (VFA) 154's float coats ended up in the water that night. This of course resulted in the activation of Man Overboard Indicators (MOBI), leading to a long search for who had gone overboard that ended in the discovery that all Sailors were accounted for and that the bag of float coats containing the MOBIs had been thrown overboard. Once the float coats had been retrieved, we realized that only two of the five MOBIs inside the float coats had actually transmitted a signal; a situation that could be extremely dangerous in the event of an actual man-overboard.

Once we arrived back to Naval Air Station Lemoore, California, our safety department began an investigation into the malfunctions and inspected all the command's MOBIs. Our safety petty officer found that we had two separate manuals from BriarTek©, the MOBI manufacturer. Both manuals described the testing process of the battery and transmitter of the TX-104 model MOBI, but they each had conflicting statements on how to properly test the devices. The first manual stated that you place the tip of the antenna on the manual activation/deactivation recess and hold it there for a minimum of three seconds. This would cause the LED on the front of the device to illuminate with a solid light. The second manual stated that after doing the same steps, the LED would flash rapidly. We contacted the manufacturer for clarification on the correct way to test the MOBIs. During discussions with BriarTek©, we discovered that both manuals were actually incorrect, and that neither manual included the correct steps for testing the MOBI transmitters.

According to the manufacturer, the proper test of the battery is to place the tip of antenna on the manual activation/deactivation recess for a minimum of three seconds. To test transmitter activation, you must either connect the two screws on each side of the device with a metal object or submerge the device in salt water. We found a paperclip worked well to connect the two screws. Either method of testing will result in a rapidly flashing light. After testing the three MOBIs that malfunctioned in the Pacific Ocean, we determined that the transmitters were faulty. After a subsequent command wide inspection, we found 25 TX-104s and 15 TX-103s (previous model) that did not properly work. The TX-103 is a completely different model that has a simple on/off switch to test both the battery and transmitter activation. The 15 malfunctioning TX-103s were due to bad batteries, not a faulty transmitter. Of the 25 TX-104 models that did not function, four malfunctioned due to failed batteries and 21 had faulty transmitters. Even though there were several that only failed the battery test, there is still a serious safety concern with these devices. Overall, our command had a 24 percent MOBI failure rate a total of 40 of 160 devices.

During the investigation into our MOBI inventory, we found two additional key discrepancies that could cause the devices to not function properly. The first issue discovered was improper antenna routing. The manuals for both TX-103 and TX-104 MOBI models state that the transmitter must be worn so that when the water sensors are under water and wet, the antenna remains above the water surface. When installed in a float coat, the antenna should be routed up and over the shoulder to ensure that part of the antenna will be above water while the person is floating. The second discrepancy was slightly more difficult to detect. If the battery door is overtightened, the MOBI will not transmit. Our team discovered the battery door should be tightened to 45 inches per ounce of torque; even though the manufacturer's recommendation is to simply hand tighten the door. To mitigate this potential malfunction after battery replacement, always test the transmitter for proper functionality.

To ensure the safety of personnel and promote an effective safety culture, processes should be established to ensure equipment is always maintained and in good working order. Our team recommends that every command equipped with MOBIs in their inventory test the batteries and functionality of their transmitters, and verify the antennas are properly routed over the shoulder.

NEAR MISS REPORTS:
WHAT THEY ARE AND WHAT THEY DO FOR YOU

By John C. Williams

There are three categories of mishap reports available in the Enterprise Safety Applications Management System: mishap reports, property damage reports and near-miss reports. The mishap and property damage reports are self-explanatory, but the near-miss reports category does need additional explanation. This category has the potential to save more lives than the first two report categories combined.

The National Safety Council defines a near-miss as: "An unplanned event that almost results in a fatality, injury or property damage event. A fortunate break in the chain of events is the only thing that prevents a mishap from occurring."

Such events occur on an almost daily basis sometimes without our knowledge. We often hear people say that it was his or her time to go after a fatal accident claims the life of a coworker. As medical technology has advanced in curing the top three causes of death – heart disease, cancer, and stroke - the average lifespan for Americans has increased over the last half-century. According to the Centers for Disease Control, the lifespan of an American male born after 1949 is 82 years, so if a worker is killed in a preventable mishap, and he or she is younger than 82 years old, it wasn't their time to go!

Most people are unaware of the hidden dangers that surround them on a daily basis, which is why near-miss reports are so vital to maintaining a safe working environment. You can see from the mishap hierarchy in figure 1 that each fatality comes on the heels of a number of injury causing or property damaging mishaps; which in turn come on the heels of an even greater number of near-miss events. It seems strange how no one seems to recognize a danger or hazard

Figue 1: Mishap Hierarchy

until someone is killed. Then suddenly, everyone knows about the issue and when the victim's coworkers are interviewed, they all claim they knew about the hazard, but failed to report it.

In fiscal year 2014, active-duty and Department of Defense civilian employees assigned to the Naval Computer Telecommunications Area Master Station, Pacific (NCTAMS PAC) submitted 23 near-miss reports; the following fiscal year, the command experienced a 25 percent decrease in mishaps. We are not making a direct correlation between the number of near-miss reports submitted and the number of reportable mishaps tallied, but one cannot completely dismiss the effect these near-miss reports had on the command safety climate. After all, not every near miss involves finding and deactivating a landmine. We are charged with calling attention to different types of hazards and risks that are out there, and yes some hazards can be likened to land mines just waiting for an unsuspecting victim.

In August 2015, a Sailor assigned to the Naval Information Operations Command (NIOC) injured his foot while playing barefoot on the sandlot volleyball court in front of the bachelor enlisted quarters. The ball was hit over the fence; so the young man jumped over the fence to retrieve the ball and upon jumping back onto the court, he landed on the edge of a rusty metal pipe that was lying on the ground. Should he have been wearing foot protection? The answer is yes, but how many of us think twice about kicking off our shoes or sandals when playing a pick-up game of volleyball? This is why we solicit near-miss reports, because you may be the only person who recognizes the hazard. We are often so focused on the tasks at hand that we don't recognize danger or perceive the hazards around us. Ten minutes spent filling out a near-miss report can prevent days, weeks or even months of recovering from a severe injury or even a death caused by a hazard that someone else recognized but failed to report.

Remember, a near-miss is an event that almost causes a serious injury but doesn't. If such an event occurs, and you're not sure if it rises to the level of a full-blown mishap, alert your supervisor and division or department safety representative or call the safety office for support. Safety is everyone's responsibility and our actions could prevent injury or save a life.

Mr. Williams is the NCTAMS PAC safety officer. He also serves as the command's traffic safety and ORM instructor.

SAFETY FIRST, SAFETY ALWAYS!

ADDITIONAL RESOURCES

Enterprise Safety Applications Management System

▶ https://esams.cnic.navy.mil/

VFA-213 BLACKLIONS

SAFETY ISSUES AND PROGRAMS

By AM1(AW) Gregory J. Zybak

Since deploying aboard USS George H.W. Bush (CVN 77) as a representative of the Safety Department, I have witnessed and noted several recurring safety issues. The two major areas of concern in which most injuries occur within the skin of the ship and the flight deck. Even with awareness of the potential hazards from training to mitigate dangerous situations, we have still seen numerous injuries during deployment.

Safety Issues

INSIDE THE SHIP: Within the skin of the ship, personnel will encounter both obvious and subtle risks. Ladder wells always present a common and unavoidable area for hazards. Sailors should remember that maintaining three points of contact is essential when climbing and descending ladders to reduce the possibility of injury. Injuries to ankles, knees, and wrists from falling or missing steps are a persistent trend. Personnel not paying attention to hand placement and where others are walking have been contributing factors to these injuries. Additionally, warmer temperatures at sea can cause condensation on passageways, catwalks and ladders which only exacerbates an existing hazard. Ensuring that all shipboard personnel are provided the appropriate information and training about how weather can affect conditions inside the ship will help limit these incidents. Finally, unexpected increases or fluctuations in air pressure throughout the ship can lead to doors, hatches, and scuttles to close without warning, posing a danger to Sailors. Personnel not paying attention to hand placement, accompanied with lack of positive control of hatches, have received lacerations, sprains, and in some cases loss of an appendage along these common access points.

The hangar bay is another major area of concern; personnel transiting the hangar bay encounter a range of potential hazards. These potential hazards range from aircraft flight control surfaces, general servicing equipment, tie-down chains, stored aircraft equipment, fuel and hydraulic fluid all of which pose a significant hazard to personnel. A Sailor's eyes have to be continuously on the move, and their heads constantly on a swivel in the hangar bay. Personnel have hit their heads on flight control surfaces, tripped over tie-down chains, had legs pinned under stored aircraft equipment that shifted under the motion of the ship, and had fuel or hydraulic fluid get in their eyes. Accidents can happen, but maintaining situational awareness, wearing appropriate personal protective equipment (PPE) and being in tune to you surroundings can help prevent these sorts of things from occurring. Moreover, experienced Sailors need to watch out for junior Sailors, providing them the necessary mentorship to increased understanding of how important safety is aboard the ship and in every aspect of their lives.

THE FLIGHT DECK: Working on the flight deck of an aircraft carrier is one of the most dangerous jobs in the world. Dynamic operational tempos and ever-changing environmental conditions continuously shape and reshape the hazards presented to flight deck personnel.

The first line of defense while on the flight deck is PPE; a cranial with goggles, leather gloves, steel-toed boots, float coat, long sleeves, and pants are required to take part in flight operations. Improper wear of PPE or degraded PPE (worn-out Velcro straps on cranials and worn tips or soles of boots) is not only a common occurrence, but unnecessarily exposes personnel to hazards, including flying debris, aircraft fluids, tie-down chains, arresting cables, and steam. The appropriate condition and wear of float coats is important for the safety of Sailors wearing the float coat. It is not only the responsibility of the wearer, but also those around them. Some float-coat discrepancies have included missing carbon dioxide (CO2) actuating device securing nuts, shear wire not installed or broken on the CO2 device, and the improper wear of or securing of the side snaps on the float coat while on deck. Personnel report that comfort and temperature have been the causal factors behind improper wear of the float coats; however these factors are no excuse for sacrificing personal safety.

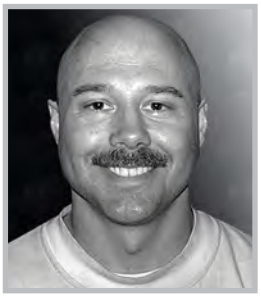
During aircraft start up, taxi, launch and recovery, many events are occurring simultaneously, creating a number of potential hazardous situations. Common concerns include personnel in the way of taxiing aircraft, standing behind aircraft exhaust, standing too close to a jet blast deflector during aircraft run-up, entering the landing area during a recovery cycle, or crossing the foul line while an aircraft is being launched off the catapult. Complacency and lack of training or proficiency on the flight deck have been the

stand-out causal factors related to these issues. Vigilance among experienced Sailors is required to ensure the safety of all personnel on the flight deck.

A common environmental issue, on the flight deck is heat; proper hydration, specifically by having a hydration pack such as a Camelbak© while topside is essential. Ensuring those assigned to flight-deck duty are allowed regular breaks to get out of the heat – ideally into an air conditioned space – is another step toward preventing heat-related incidents.

Safety Programs

Flight-deck awareness training, personnel qualification standards, and mentorship are tools we must utilize in order to disseminate the necessary knowledge to inexperienced Sailors. It is every Sailor's responsibility to maintain awareness of what is going on around them. And, it is everyone's responsibility to look out for those around them and maintain the standards to ensure safe conduct when aboard the ship. All it takes is one correcting interaction to interrupt the chain of events that could lead to injuries and mishaps. Taking steps to mitigate these hazards should be, and must be, as important as the mission itself.



AM1(AW) Gregory J. Zybak is the safety petty officer and assistant command fitness leader for Strike Fighter Squadron (VFA) 213 deployed aboard USS George H.W. Bush (CVN 77).

Sailors prepare an F/A-18E Super Hornet attached to the "Tomcatters" of Strike Fighter Squadron (VFA) 31 to launch from the flight deck of the Nimitz-class aircraft carrier USS George H.W. Bush (CVN 77) to conduct flight operations in support of Operation Inherent Resolve June 6, 2017. George H.W. Bush is conducting naval operations in the U.S. 6th Fleet area of operations in support of U.S. national security interests. (U.S. Navy photo by Mass Communication Specialist 2nd Class Christopher Gaines)

THE IMPORTANCE OF PERSONAL PROTECTIVE EQUIPMENT

By AN Jonathan Munsill

Working on the flight deck during flight operations is one of the most exhilarating and dangerous jobs someone could ever perform. Aircraft are rapidly launching and recovering while all around the flight deck, crews are hard at work. While working on the flight deck, safety is paramount and proper use of personal protective equipment (PPE) is essential to staying safe.

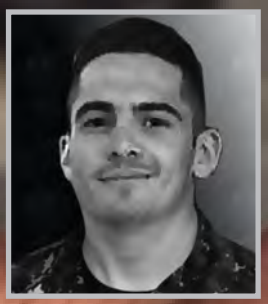
After servicing engine oil on an E-2C Hawkeye, I was climbing down from the flight deck onto a catwalk; I took my first step and my left foot slipped out from underneath me. The weight of the fluid servicing unit (FSU) and bucket I was carrying overcame my balance, sending me head first into the catwalk. On my way down, I hit my head on something hard before coming to rest on the metal grate of the catwalk. My legs slammed into the stairs before they rolled onto the metal grate. Luckily, I walked away from the incident with only a bump on the head and some bruises. My cranial prevented my head from making direct contact with the deck of the catwalk, preventing serious injury. Had I not been wearing my cranial, I could have suffered a concussion or even lost consciousness. This important piece of PPE did its job and kept me safe.

My cranial had been properly inspected and signed for when I got to work that morning. If I had not done my inspection or used my PPE properly, I would have been seriously hurt in that incident. It only takes a few minutes every day to properly inspect and ensure that your PPE is working properly, and it only takes a few seconds to put it on. Those few minutes were the difference between walking away from the incident and being carried away on a stretcher.

AN Munsill serves in the line division with Carrier Airborne Early Warning Squadron (VAW) 116.

SAFETY
THROUGH AND THROUGH

By ADAN Anthony Haga



ADAN Haga serves as an aviation machinist's mate with Carrier Airborne Early Warning Squadron (VAW) 116.

Editors Note: Image is of the actual injury sustained by the author, ADAN Anthony Haga.

Everyone has had a time when they did not get enough sleep. Some people deal with a lack of sleep better than others. One person may only feel slightly groggy in the morning, while another feels like they are the walking dead all day long. Either way, it is important to realize when you are not as well rested as usual and take the proper precautions, especially in the work place.

On Feb. 16, 2017, I came to work at 6 p.m. after having stood watch from 12 a.m. to 8 a.m. the same day. I was tasked to work on an aircraft, safety wiring the beta feedback target mounting bolts on a propeller blade. As I was safety wiring the bolts, the wire snapped and penetrated my left thumb, going through to the other side.

I had followed each step of the procedure correctly and had been wearing the appropriate personal protective equipment; however, the wire still snapped and I still ended up with a piece of metal sticking out of my thumb. The only outside factor I could identify was the fatigue from working an eight-hour duty shift during normal sleeping hours; which left less alert than I should have been on the day the incident occurred.

Staying alert and practicing good operational risk management (ORM) by utilizing the following simple five-step process can help reduce the probability of a workplace injury.

These five steps are:

1. **Identify hazards**
2. **Assess the hazards**
3. **Make risk decisions**
4. **Implement controls**
5. **Supervise and watch for change**

Sometimes you can take all the proper precautions, but accidents still can happen. It is important to recognize all the internal and external factors that are in place. In this case, I was fatigued and something may have gotten past my usual scan. I was lucky to have been able to walk away with such a small wound and only having missed a few hours of work.

Exploring Risk Management

By LTJG Kate Harrell

It's always an exciting time when you arrive to a new ship – meeting new shipmates, learning about the ship, and exploring all the passageways and nooks of the place you will call home while underway. Although exploring can be fun, we should always remember that there is an inherent risk with anything that we do onboard a ship, and we should always manage the risk associated with those activities.

It was my third day on a ship, everything was new; all the passageways and hatches looked the same to me. I had memorized the route from my stateroom to the ready room. From the ready room, I knew how to find the galley, the hangar bay, and my work center. In the first two days of my arrival, other officers had taken me on tours of the ship; I'd seen the mess decks, the cashier's office, medical, and the gyms. I knew how spaces were numbered and understood that I should be able to find my way back to my stateroom, but I had already gotten lost in the maze of the ship a few times. Each time I got lost, I would wander around hoping to come across some recognizable landmark from my previous tours. After losing my way several time, I made the decision to stick to only the routes I had already learned for at least for a few days. Until I got my bearings, even if this meant leaving my stateroom, going upstairs to the ready room, and then proceeding back down two ladderwells to get to the hangar bay.

The next night, as I went to take the ladderwell from the ready room down to my stateroom, I felt a drip from the pipes above. Looking down I realized the top stairs were wet. My adherence to the plan I had made — I don't know another way back to my room, I'll have to take this way —made me override my good judgement. As I climbed the ladderwell I thought, "Oh, this could be dangerous … maybe I should take another ladderwell." No sooner had this thought entered my mind when I lost my footing on wet treads and slid down the stairs. My left pinkie got tangled in the crossbar of the handrail, causing my fifth metatarsal (my pinkie hand bone) to break. The space of time between when I realized the ladderwell was treacherous and when I began slipping was fast, just a second or two.

I remember clearly comprehending the danger and ignoring it; a decision that was needlessly risky. I was not in a rush, there were certainly plenty of other routes I could have used, and I could have asked someone for help or notified someone about the hazard. I put adherence to my plan over my own safety and spent the rest of the underway in a cast.

LTJG Harrell graduated from Navy Basic Intelligence Officer Course in June 2015 and is currently serving as the aviation intelligence officer for Carrier Airborne Early Warning Squadron (VAW) 116.

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