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ASMIS 2.0

Army Safety Management Information System

ASMIS 2.0 IS A TOTAL ARMY SAFETY & OCCUPATIONAL HEALTH SOLUTION THAT:

- Is a modernized, adaptive and flexible family of software systems that will support current and emerging Army requirements while subsuming all duplicative systems.
- Leverages external authoritative data from agencies across DoD to proactively aid leaders and SOH personnel to target loss prevention and preservation of resources.
- Includes streamlined applications with less burdensome data entry, intuitive step-by-step guidance and fewer required data points that will result in lower reporting times.
- Will do away with paper mishap forms.

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RISK MANAGEMENT
LEADERS SOLDIERS CIVILIANS FAMILIES
SUMMER 2026

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MISSION STATEMENT:

The U.S. Army Combat Readiness Center preserves Army readiness through analysis, training, and the development of systems that prevent accidental loss of our people and resources.

Stackin

What Jenga Tea

ng the Odds:
ches Us About Army Readiness

CHRIS ACORD
DIRECTORATE OF ANALYSIS AND PREVENTION
WORKPLACE SAFETY DIVISION
U.S. ARMY COMBAT READINESS CENTER
FORT RUCKER, ALABAMA

Imagine you are playing Jenga. The 54-wooden-block tower wobbles, seems to hold for a second and then collapses — not because of a player's last move, but because multiple missing and restacked pieces quietly weakened the structure. Army readiness fails the same way: One visible act is the result of long-term ineffectively assessed hazards, eroded procedures, training shortcuts and a failure to consistently enforce standards. The Human Factors Analysis and Classification System 8.0 (HFACS 8.0) helps expose those hidden failures after a mishap. But more importantly, HFACS shines a light on these failures before they manifest into mishaps through inspections and risk assessments, which the Army Safety Management Information System (ASMIS 2.0) gives commanders through targeted feedback to prevent the next collapse. The following will explore how Jenga's missing blocks and nonlinear failure dynamics translate into practical checks leaders can use to enhance readiness today.

Why Jenga Works as a Metaphor for Operational Readiness

The Jenga tower is your safety system, and each block is a risk control — policies, procedures, training, leadership actions and resource support. In a perfect tower, every risk control is fully implemented and consistently evaluated for effectiveness. Removing a couple of blocks to meet a mission demand creates a small weak point, yet the tower still stands. Herein lies the trap. Success breeds a false confidence that hides where the instability from shortcuts over days, weeks and months continues to intensify. Remove several more blocks and the structure becomes more fragile until a single tug triggers a collapse. This insidious drift is known as "normalization of deviance," and leaders must be intentional in preventing it from taking root.

We all know Army operations are never static. Removing a block and restacking it mirrors the daily reality of the mission:

- Resource support – Budget cuts reduce supplies, maintenance and personnel.
- Training shortcuts – Personnel lacking experiential learning and feedback.
- Ineffective standards – Outdated, absent or unclear standard operating procedures (SOPs), technical manuals (TMs) and policies.
- Leadership acceptance of risk – Risk deviation from a standard is tolerated to meet mission requirements, resulting in a dangerous precedence.
- Individual strain – Fatigue, inexperience and stress, resulting in a lack of attention to task.

The Missing Blocks: System Inadequacies (the roots of organizational weaknesses)

Look beneath the wobble. What appears as a single error or hazardous behavior is usually a stack of "missing blocks." These are the hazardous conditions created long before a near miss or mishap occurs. Army Techniques Publication (ATP) 5-19 and Department of the Army Pamphlet (DA Pam) 385-40 define these root conditions as system inadequacies. The HFACS provides a powerful lens to identify these five critical mishap barriers:

- Leadership and supervisory failures: Ineffective risk assessments and planning; ineffective supervisory oversight, weak standards enforcement, permissive command climate.
- Training failures: Outdated program of instruction, unavailable or mismatched unit training shortcuts in execution.
- Standards and procedural failures: Unclear, outdated or impractical policy or procedures.
- Support and resource failures: Staffing shortages, funding cuts, broken/dead-lined equipment, inadequate infrastructure.
  Individual inadequacies: Inexperience, stress, operationally and/or individually induced fatigue or complacency that result from a combination of the other four failures.

When units stack workarounds, such as temporary fixes and procedural shortcuts, they raise the tower's center of gravity and increase instability. The system becomes taller and more fragile until one move triggers a collapse.

Nonlinear Reality of Human Factors: Why the Tower Falls Suddenly

Failures don't add up; they multiply exponentially. Small, dispersed changes produce disproportionate outcomes. A budget cut with an increased OPTEMPO and personnel shortage at the base of the system forces a leadership decision to accept risk, which shortens training, which produces inexperienced or untrained crews. Then, a single unsafe act triggers a catastrophic outcome. The HFACS helps safety personnel and their commanders to look beyond the final error of the operator. Its purpose is to aid in tracing these hidden, non-linear pathways of error back to the roots of the system inadequacies so you can make corrections to re-strengthen the system.

When your safety personnel conduct inspections or investigate mishaps, they should start with curiosity: What is allowing this hazard to exist? What was accepted, deferred or ignored? Why was something accepted, deferred or ignored? How can we plug the hole?

Why this Matters for Army Leaders and Their Safety Personnel

For leaders, the Jenga metaphor proves four uncomfortable truths:

1. Risk is never static; it is constantly evolving, even after completion of a deliberate risk assessment.
2. Latent organizational failures are far more dangerous than individual errors.
3. Small, ignored errors don't just add up in plain sight; they covertly multiply.
4. Every system appears stable right before it collapses.

If the problem is systemic, the solution must be systemic. This demands a shift from a defensive posture of reacting to lagging failures to proactively hunting instability and attacking it early. Your job is to see the wobble before it becomes visible and to reinforce the base. Do these consistently and the tower will move without falling:

1. **See the whole tower – assess leading indicators.** Track leading indicators from inspections and reported hazards versus the lagging indicators of mishaps.
   - Schedule regular reviews of maintenance logs, training rosters, supply status and the ASMIS 2.0 Program Management module to assess system inadequacy/latent failure trends of hazards. Data from the ASMIS program management dashboard and the Joint Risk Assessment Tool (JRAT) will help prioritize corrective actions that address root causes before they manifest into mishaps.
   - Direct your safety personnel to use HFACS 8.0 to:
     - o Determine the root system inadequacies/ latent failures of hazards during workplace inspections, then document them in the ASMIS Inspections and/or Hazard Management modules.
     - o Treat near misses as mishaps and hunt down the system inadequacies.
   - Direct your leadership team to use HFACS 8.0 to:
     - o Augment ATP 5-19 while conducting pre-mission deliberate risk assessments and capture the leading indicators from risk assessments in JRAT.
     - o Aid in the development of a Job/Activity Hazard Analysis and document the system inadequacy controls in the ASMIS 2.0 Supervisor's Portal.

2. **Encourage reporting – *treat near misses as intelligence, not embarrassment.*** Your Soldiers and civilian personnel are the first to feel the tower getting unsteady. They know which procedures are

flawed, who is inexperienced and where resources are thin. Normalize and reward near-miss and hazard reporting. Make it safe to say, "This feels wrong," provide timely feedback and act on reports.

3. **Map the chain – hunt down and attack the system inadequacies.** Direct your safety personnel to use HFACS categories as part of inspection checklists and hazard analysis. For every near miss and hazard discovered or reported, map them back to their root reasons for existence and review them over the prior 30, 60, 90 or 120 days.
4. **Fix the fix – prioritize systemic fixes.** Replace workarounds with durable solutions, document temporary measures and set deadlines for permanent fixes. Require after-action reviews (AARs) with your leadership team and direct your safety personnel to feed findings into the corrective-action plans captured in the ASMIS Hazard Management module.

Conclusion

Catastrophic failures are never the result of a single error. The five-year trends of the Army's "Dirty Dozen" (https://safety.army.mil/MEDIA/Safety-Brief-Tools) demonstrate the same truth that most latent failures derive from supervisory and training inadequacies, which foster a normalization of deviance. The final lesson from Jenga is not about preventing movement, it's about having a profound respect for the STKY (stuff that kills you) and intelligently managing instability.

Our systems are never static. People quickly migrate to shortcuts, missions creep and variability is a constant. The true challenge for a leader is to understand how these shifts interact and where risk is silently accumulating. The objective is not to freeze operations but to manage variability so the subtle movements never collapse the tower.

Leaders who embrace the HFACS and ASMIS tools with disciplined inspections and leading-indicator metrics will find and fix missing blocks before the final pull. When leaders view their formations through this lens, recognizing the interconnected, non-linear nature of human factors, they build resilience. They step back from focusing on individuals who committed the last act to focusing on the tower as a whole and humbly striving to reinforce the entire structure. In the end, the goal isn't to keep the tower from ever moving; it's to ensure it never has to fall and all players in the game get to go home at the end of the mission.

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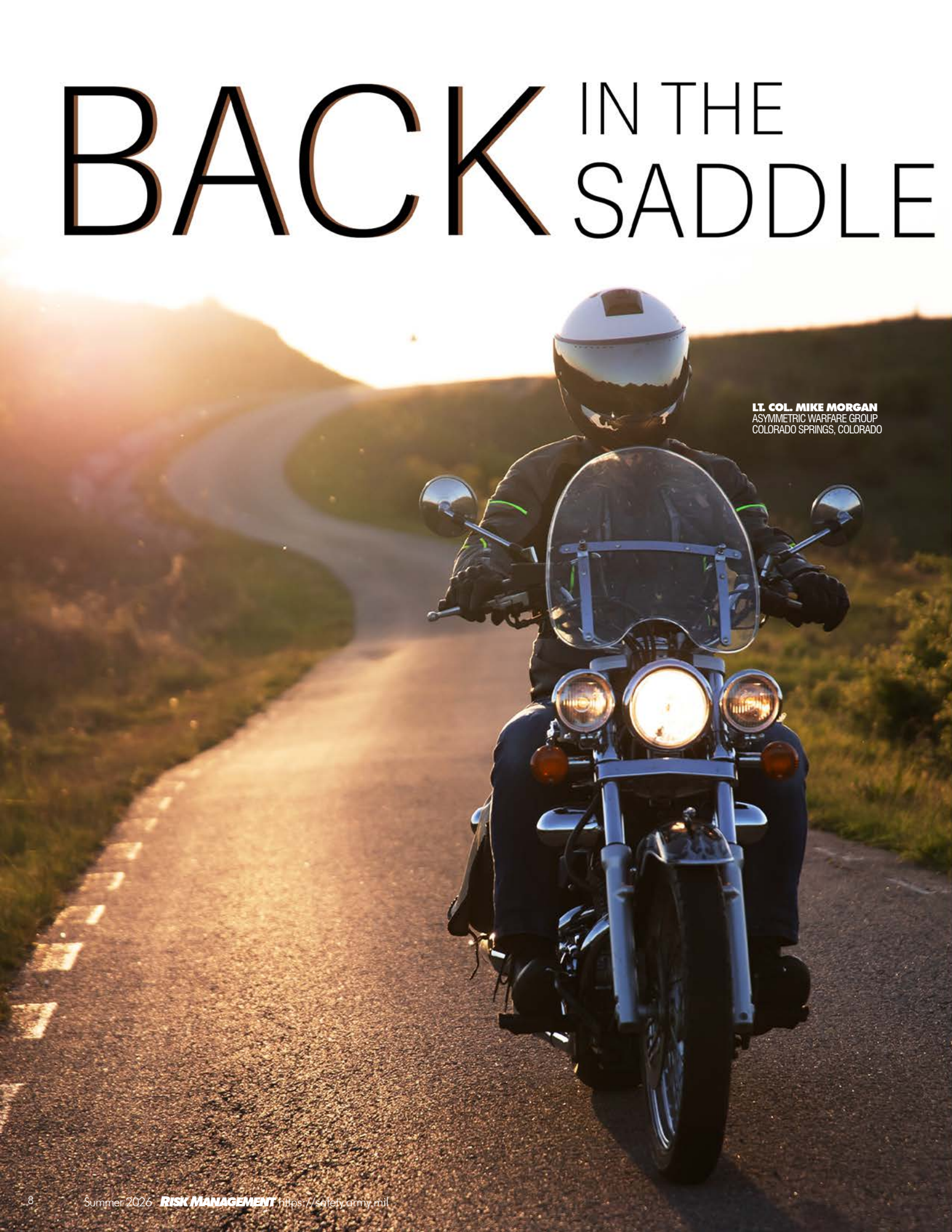
BACK IN THE SADDLE



LT. COL. MIKE MORGAN
ASYMMETRIC WARFARE GROUP
COLORADO SPRINGS, COLORADO

Just get back from a deployment? How about a mid-tour leave? Or maybe you're just getting ready to ride again after a winter break. If you're like me, you're probably itching to take your bike out for a long-overdue ride along some back country roads. A couple of years ago, while home from Afghanistan, I got back in the saddle again, enjoying the freedom only a motorcycle provides. During my leave, I covered nearly 900 miles without a scratch — something to consider when you think about how many Soldiers die on their bikes soon after returning home. Here are some tips to help keep you safe.

Use your head

The most important thing you can do is a good risk assessment. This doesn't necessarily have to be difficult. It's mainly using common sense and good judgment to blunt some of your eagerness to do things you shouldn't when you first get back. The things I considered in my personal risk assessment included the condition of my bike, length of my rides and time when I rode. I also considered whether to carry passengers and where I would ride.

Is your bike ready?

You hated putting your bike into storage before you left. I'm certain you did all the right things like changed the oil, connected the battery to a trickle charger and put stabilizer in the fuel. Now that you have returned, it's time to be just as meticulous about your bike's maintenance before riding it on the road. Check the pressure in your tires because it will have gone down. Check your cables to see if they need adjustment. Ensure the nuts and bolts that were tight when you left are still tight now. Dust off your Motorcycle Safety Foundation training and use T-CLOCS — Tires, Controls, Lights, Oil, Chassis and Stands — as a guide as you check your bike.

Plan a reasonable ride

When I first got back, I wanted to take a 600-plus-mile ride from Fayetteville, North Carolina, to Fort Campbell, Kentucky. However, that would have been a high-risk trip because of the hot weather, my need for rest, the length of the ride and the unfamiliar terrain. Instead, I took short rides — none of which lasted much longer than an hour — to brush up on my skills. To reduce my risks, I began by riding on back country roads, where I would encounter less traffic. Also, I didn't carry any passengers at first because that dramatically changes a bike's handling. Additionally, I avoided riding at night because of the reduced visibility and huge bugs, which make things less enjoyable. When I did ride after dark, I kept to routes that had bright streetlights.

The downside to riding mainly during the day, however, was afternoon temperatures often topped 100 degrees Fahrenheit. As my rides got longer, I needed to make sure I kept myself hydrated. One afternoon, as I was riding back from Myrtle Beach, South Carolina (about a 3½-hour ride), I had to take a 30-minute break to drink some Gatorade and sit in the shade. When you're riding and enjoying the breeze, it's sometimes hard to realize just how hot it is.

I also avoided riding in metropolitan areas at all costs. I'm convinced it's a high risk for bikers anytime they ride around a city's shopping district. The worst thing a biker can see in their mirrors is a minivan full of out-of-control kids with the driver talking on a cellphone. There are a lot of vehicles that fit that profile in congested urban areas.

"IF YOU'RE A LEADER WITH SOLDIERS WHO RIDE, SHOW THEM THEIR SAFETY IS YOUR CONCERN. AS SOLDIERS, WE ARE RESPONSIBLE TO KEEP EACH OTHER SAFE. "

Adjust your attitude

Even though I've been riding for quite a while, I still think of myself as a novice. I keep that attitude because I still want to be riding in my 90s. If you start thinking you're good, you're likely to get overconfident and turn into an accident waiting to happen. That's why I broke myself in slowly when I first got back, treating every ride as a training session so I could get used to cornering, braking, scanning and positioning in traffic. These are all skills that require constant refinement regardless of a rider's experience level.

The intersection of safety

When I'm sitting at a red light, before the light turns green, I try to make eye contact with as many drivers as I can. You can never tell what type of effect this has; it's just something I like to do. The key, however, is realizing you'll always come out as the loser in a right-of-way confrontation with a car or truck at an intersection, regardless of what the traffic light says.

Wear safety gear

I wear the required personal protective equipment (PPE) whenever I ride. Most PPE is reactive, being designed to help you survive a crash. However, one piece of PPE that can help prevent a crash is good protective eyewear. While I was home, I bought a fitted pair of Wiley-X goggles with foam cups designed to keep the wind out of my eyes. They cost way more than I would have ever expected to pay for glasses, but it was worth it to see clearly and keep my eyes from drying out.

Drinking and riding

I saved this one for last. The bottom line is that I just didn't do it. This is an area of personal responsibility that, despite countless safety briefings, counseling and policy letters, ultimately rests on your shoulders. If you're redeploying from an alcohol-restricted tour, I can understand your desire to imbibe. However, for your sake and that of your friends, family and unit, please don't drink and ride.

Conclusion

Riding is a sport that befits a band of brothers and sisters. If you're an experienced, safety-conscious rider, mentor a Soldier who is new to the sport. If you're a leader with Soldiers who ride, show them their safety is your concern. As Soldiers, we are responsible to keep each other safe. How can we do anything less?

DID YOU KNOW?

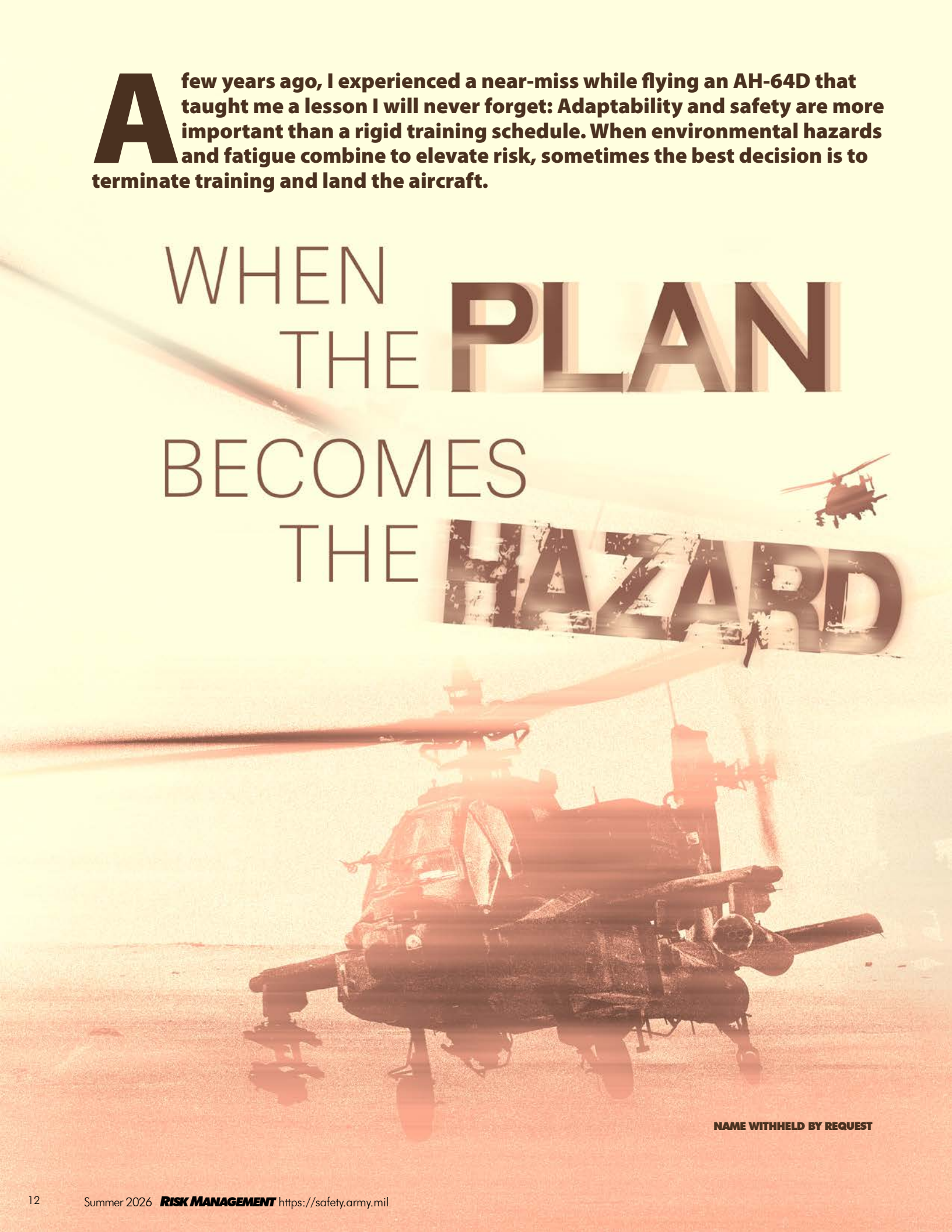
Army Regulation 385-10 requires Soldiers to successfully complete the Motorcycle Safety Foundation's (MSF) Basic RiderCourse (BRC) before operating a motorcycle. Within 12 months of completing the BRC, Soldiers must undergo a second round of training in the Advanced RiderCourse (ARC). Sustainment training in the form of the ARC is mandatory every five years after initial completion. For individuals who have been deployed for 180 days or longer, there is now an additional requirement to attend the Motorcycle Refresher Training course. This course can be taught at the local level without a certified MSF RiderCoach. These classes are free to Soldiers.

FYI

For a 15-point checklist to help bring your motorcycle out of its winter hibernation, check out this Risk Management article: https://safety.army.mil/MEDIA/Risk-Management-Magazine/ArtMID/7428/ArticleID/6890/Spring-has-Sprung-Time-to-Awaken-the-Beast. ■

A few years ago, I experienced a near-miss while flying an AH-64D that taught me a lesson I will never forget: Adaptability and safety are more important than a rigid training schedule. When environmental hazards and fatigue combine to elevate risk, sometimes the best decision is to terminate training and land the aircraft.

WHEN THE PLAN BECOMES THE HAZARD



NAME WITHHELD BY REQUEST

Incident summary

In the desert setting of Fort Bliss, Texas, degraded visual environment (DVE) training is essential to aircrew readiness. Our unit commander had recently emphasized the importance of ensuring crews remained sharp on both DVE landings and terrain flight techniques. We were scheduled to take off early in the afternoon for a single-ship training flight to accomplish those tasks, taking advantage of the calm conditions typical for that time of day. Unfortunately, some unexpected maintenance delays pushed our mission into the late afternoon.

After bumping out of two aircraft, we finally launched about 1600. By that time, however, our ideal weather had passed and the winds were picking up. We pressed on, completing the terrain flight operations before heading to a dusty landing zone to practice DVE landings.

During our initial low-level recon of the landing area, we noted that the winds were extremely variable and stronger than expected. We were having trouble determining the most favorable approach path. As we began our descent, a strong tailwind developed right as the dust cloud enveloped the aircraft. We descended rapidly and entered a slight bank just a few feet from the ground. As we were buffeting in the air, the pilot on the controls became disoriented and immediately aborted the approach. We made the call to terminate the flight and returned to the airfield.

Hazard and human factors analysis

It's often said that a near-miss is just inches or seconds from a catastrophic mishap. While our incident seemed minor on the surface, a closer look revealed several factors that compounded to create a serious situation. Understanding each factor helps us prevent a similar situation in the future.

- Environmental factors: We conducted the flight later than planned, which introduced higher winds and turbulence that were not present earlier in the day. Desert environments have highly variable wind patterns, and we failed to account for this change adequately in our go/no-go decision. Our initial briefing and risk assessment were based on a midday weather forecast, which became irrelevant hours later.
- Schedule pressure: Our motivation to complete the training objectives, despite the delays, was a significant factor. Both our crew and maintenance personnel had a long day. We felt an internal pressure to get it done, check the box and move on. This pressure can override good judgment and encourage a crew to accept greater risks than they normally would.
- Crew fatigue: The long delays and the demands of the preceding terrain flight had left us mentally fatigued. This degraded our cognitive function and likely made the pilot more susceptible to spatial disorientation. Had we been fresh, we might have identified the escalating risk earlier and scrubbed the dust landings.
- Refusal to adapt the plan: Our most critical error was refusing to adapt the plan as conditions deteriorated. Faced with gusting winds and crew fatigue, the correct decision would have been to switch to a less demanding training objective, such as traffic pattern work. Continuing with the original objective, despite new hazards, was a clear failure of dynamic risk management.

Lessons learned

The most important lesson from that day is that risk management must be a dynamic process. We began with a solid plan, but when maintenance delays and changing weather introduced new variables, that plan became a hazard. The right decision was to not force the objective, but to recognize the new reality and adapt. This incident serves as a constant reminder that a pilot's best tool is their judgment. Mission success is not defined by completing every task, but by ensuring everyone returns home safely.

DID YOU KNOW?

The Army Safety Management Information System (ASMIS 2.0) Mishap and Near-Miss Reporting application provides a means for users to submit all classes of mishaps, as well as near misses. The tool was created to reduce the burden of reporting on safety officers and to improve decision-making by reducing the amount of data required and by providing enhanced visibility of mishaps and near misses at all levels of the Army. Check it out at https://mishap.safety.army.mil/. ■

More Than a License: Driving a Culture of Safety and

As a brigade master driver, I found myself buried in preparation for an upcoming block of driver training. My mission was simple — find a slide deck for the Family of Medium Tactical Vehicles (FMTV). Yet, the time I spent hunting for that one resource was time stolen from a dozen other critical tasks. That initial search for the slides was just the beginning. Ahead lay the mountain of printing and grading tests, filling out evaluation sheets and manually building individual driver packets — records that are notoriously easy to lose or damage, instantly invalidating hours of work.

Staring at the pile of paperwork, I knew there had to be a better way. The Army Driver and Operator Standardization Program is critical to our readiness and the safety of our Soldiers, but its administrative burden was bogging us down. If a better system didn't exist, I would create one. I set out to build a digital framework that would not only meet every requirement of Army Regulation 600-55, but also simplify our processes, enhance our training effectiveness and increase our units' lethality.

The Core Challenge: A Program in Need of a Modern Overhaul

The greatest challenge facing the Army's Driver Training Program is that it often doesn't receive the same emphasis as other key readiness programs. This is clear in its structure. At the battalion and brigade levels, the master driver is an additional duty, typically assigned to an already overloaded operations sergeant. As an "additional" responsibility, it rarely gets the full attention it deserves. This is compounded by the sheer time required to execute the training properly. A single week of driver training for one vehicle platform can consume immense administrative effort:

- Test Administration – Printing, distributing, collecting and hand-grading exams results in significant time lost for instructors and leaders.
- Form Preparation – Manually filling out DA Forms by hand for each Soldier leads to inconsistencies and errors.
- Recordkeeping – Maintaining physical driver packets results in lost, damaged or incomplete records, especially during PCS moves or deployments.

These administrative hurdles don't just waste time; they create inconsistencies in training and documentation, making it difficult to track qualifications and ensure every Soldier is truly proficient.

The Solution: A Digital Framework for the Modern Warfighter

My goal was to create a system that would slash administrative time, distribute responsibility to the lowest level and empower our non-commissioned officers (NCOs). The digital program management framework I developed was built on simple, accessible technology and designed to be mobile, user-friendly and scalable. We introduced several digital products for use across the brigade:

- Digital Exams: Using Microsoft Forms, we created tests via a QR code or a simple link on any smartphone. The platform automatically grades exams, provides immediate feedback to students and gives instructors powerful analytics to identify common trouble spots. This single change eliminated the entire print-grade-file cycle.
- On-Demand Student Guides: We developed standardized student guides and training slides for every platform. By making them accessible via QR code, students can pull up materials on their phones anytime, anywhere.
- Standardized Digital Forms and Packets: Pre-formatted templates for forms like DA Form 348 ensure clear, common language across the formation. Most importantly, all driver packets are now maintained digitally with a standardized file structure, complying with Army regulations while eliminating the risk of physical loss.

This digital approach places responsibility back where it belongs — with the team leader. It provides our NCOs with modern tools to perform their traditional role of training and mentoring Soldiers.

1ST SGT. CHRISTOPHER J. PAGANO
5th Squadron, 4th Cavalry Regiment, 1st Infantry Division
Fort Riley, Kansas

Proficiency

A Phased Rollout for Lasting Success

To ensure a smooth transition and lasting adoption, we implemented the program in four distinct phases:

1. Implementation (6 months) – Establish digital standards, scan all existing physical packets to digital and begin creating all new packets in the digital format.
2. Brigade-Wide Inspection (10 days) – Conduct a 100 percent review of all digital packets. The efficiency of the digital system allowed us to complete this in just 10 working days, a fraction of the time a physical inspection would take.
3. GCSS-Army Integration (3 months) – Migrate all digital packets into GCSS-Army, creating a layered and redundant digital storage solution within the Army's system of record.
4. Sustainment (Ongoing) – Continuously use, evaluate and refine the digital program to meet emerging requirements and ensure continuous improvement.

Proven Results and a Path Forward

The program's success has been undeniable. Feedback from end-users, especially the team leaders who use it daily, has been overwhelmingly positive. We've seen a dramatic increase in efficiency in all aspects of driver training. More telling, a sister brigade adopted our framework and successfully implemented it while on an operational rotation to Europe — a testament to the system's robustness and adaptability in even the most resource-constrained environments.

This program is just one example of how motivated leaders across our force can innovate to improve our systems, enhance readiness and, most importantly, protect our Soldiers. My hope is that other organizations will adopt this framework, build upon it and continue to push the boundaries of what is possible. Integrating this program into Advanced Individual Training centers, where driver qualification is a core requirement, would yield significant efficiency gains. By continuing to use and improve this program, we are ensuring our Soldiers have the training they need to win on any battlefield. ■

We are often warned about the dangers of allowing mission pressure to affect your decisions and intuition as a pilot, but there is no publication to be airdropped or memorized. My instructor pilots (IPs), both throughout flight school and in my unit, reiterated how important it was to identify and mitigate it if possible. Early in my career, I learned valuable lessons in risk management and the various types of mission pressure that can influence a crew and their decisions. This story is one example.

WINDMILL ON OUR RIGHT

CHIEF WARRANT OFFICER 2 SHANE INGRAM
1-244TH ASSAULT HELICOPTER BRIGADE
LOUISIANA ARMY NATIONAL GUARD
HAMMOND, LOUISIANA

As a newly appointed Readiness Level 1 aviator, I was ready to take on the next challenge and happy to fly with anyone other than an IP. So, when the opportunity arose to transport a UH-60M cross country, I jumped on the mission. The task seemed simple enough: depart Louisiana, overnight in Lincoln, Nebraska, and end our mission in North Dakota the following day. I had never visited the northern Midwest, nor had I flown over/through snow. I was looking forward to the sights and experience and felt lucky when I was chosen for the flight.

The first leg of the mission was fairly uneventful — blue skies and a slight crosswind persisted out of the west from fuel stop to stop until we eventually reached our overnight for Day 1. I was impressed with Lincoln's infrastructure while driving around and noted that I would need to come visit when I had more time to truly explore the city. We enjoyed some BBQ for dinner and bedded down for the night, knowing Day 2 would present slightly more of a challenge. We had been monitoring a substantial weather system to the northwest headed our way with no signs of deteriorating.

The next morning, we met in the hotel lobby and made our way to the airfield. The brisk westerly wind

during preflight was a constant reminder of the approaching weather, as well as a jab in our sides to get going. Once the aircraft was ready, our pilot in command (PC), our highly experienced crew chief (CE) and I met at the nose to discuss the execution. The system was knocking on our door, making this morning a do-or-die decision. Either we took off in the next 30 minutes and stayed east of the weather or we waited two to four days for it to pass. Yes, it was that large of a system, and the PC had strong opinions about moving forward with the mission. After a brief discussion about potential courses of action, we decided to hop in and prepare for departure.

During runup, the conditions required blade deice tests to be performed. After an initial failure, we performed the tests again, only to obtain the same result (Strike 1). This was certainly unexpected. Being from Louisiana, the deice and anti-ice capabilities are rarely used during missions. Although they are tested regularly, there were no annotations in the ACN for these particular deficiencies on this airframe.

At this point, current conditions and forecasts still called for marginal visual flight rules (VFR) conditions at worst, so we decided to proceed with runup. During this process, we also discovered the windshield anti-ice was inoperable for two of the three panels (Strike 2). The inoperable systems, coupled with the icing significant meteorological information starting at 2,000 feet mean sea level (MSL), essentially eliminated any option for climbing to instrument flight rules (IFR) altitudes for this leg of the mission. Again, after a brief discussion and checking forecasts, we decided to press on.

We departed Lincoln under marginal conditions, praying the ceiling would hold long enough to reach our destination. Unfortunately, our prayers were not heard. About 30 minutes into the flight, ceilings started dropping — 1,200, 900, 700 feet, and we descended with them (Strike 3). Now officially scud-running anywhere from 100-300 feet above ground level (AGL) depending on the terrain, our entire crew was on edge. My duty was navigation and obstacle identification along with our CE, while the PC manned the controls. I was scanning inside and out for any towers, no matter their height. At this point, if it was depicted on the sectional, it was a factor. Even flying over some traditional farm windmills had our CE calling out, either for operational or nostalgic reasons.

Still picking our way northbound, I noticed a few wind turbine symbols surrounded by a dashed line in our flight path. This being new to me, I inquired, and the PC informed me that it was a turbine farm depicted by the dashed outline that should be avoided.

I advised him to turn left to a 300 degree bearing, allowing us to circumnavigate the farm on the west side, then continue north. He executed, and I resumed my normal scan. Shortly after, our CE identified a windmill to our right. I began scanning for a traditional farm windmill to the east, like the ones we had seen earlier. What I witnessed instead will forever be engrained as a haunting memory: a solid superstructure pole rising into the low ceiling and, like something out of a nightmare, the tip of the turbine blade spinning out below the clouds, one at a time.

As eerie as the sight was, the turbine's location was verified via the map and our current heading. We were doing OK considering the circumstances. As we continued, we identified more and more "windmills" to our right, each brandishing that single blade from the cloud layer and making our bodies stiffen. Fixated on my scan sector, our CE suddenly called out a turbine to our left (Strike 4). There was a deafening silence for a second. "There's no way," I thought. We were well west of the depicted farm on the map by at least a mile with no other turbine symbols nearby. Luckily, the PC was quick to react, executing a return-to-target maneuver to exit the now-apparent farm we were traversing directly through. He leveled the wings on the exact reverse bearing and continued southeast bound until we were well clear of all turbines.

As we continued south and eventually west, remaining well clear of the farm, we noted the grid for our report. Our entire crew was certain we had remained outside the depicted farm, and we had also verified we had the latest version of maps prior to leaving home station.

Lessons learned

I had several takeaways from this experience. First, never assume unnecessary risks based on weather timing and forecasts. Second, if vital aircraft systems fail, do not proceed if you think it will become a limiting factor. Finally, navigation aids are just that — aids. Trust your capabilities as an aviator and your crew. They may just save your life. Back at home station, we contacted the Federal Aviation Administration and requested a review of the sectional. A few months later, it was updated to accurately depict the farm. ■

Being involved in a motorcycle mishap is something no rider likes to think about. Time and again we hear our commanders, safety officers or co-workers tell us to be careful, ride safely and use personal protective equipment (PPE), but do we listen? We may hear the words, but do we really believe we will be the Soldier who has an accident?

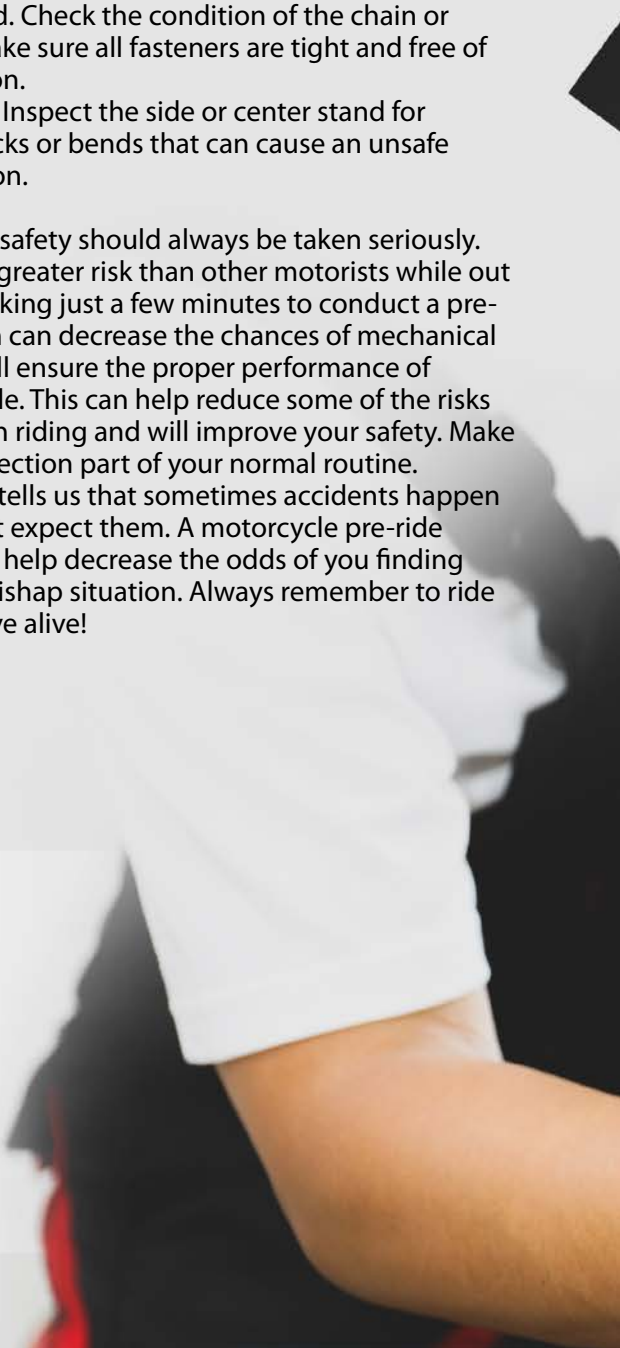
An important part of rider safety is conducting a pre-ride inspection on your motorcycle. Yet, how many times have you just hopped on your bike and took off without even a quick glance at its condition? The latest Army mishap statistics provided by the U.S. Army Combat Readiness Center (USACRC) show there were 26 motorcycle fatalities in FY25. As an Army aviator, I would never think of going out on a mission without first conducting a pre-flight inspection of the helicopter. So why would I fail to conduct an inspection on my motorcycle?

Conducting a pre-ride inspection on your motorcycle before each ride is a smart thing to do, and it might just save you from becoming the next statistic in the USACRC's mishap database. A good tool to use for your pre-ride inspection is the Motorcycle Safety Foundation's T-CLOCS checklist. The checklist focuses on the most important parts of your motorcycle that should be inspected before each ride: Tires, Controls, Lights, Oil, Chassis and Stand. A brief description of each of these areas follows, but for a complete description, be sure to use the entire T-CLOCS checklist.

- Tires – Always check your tires, wheels and brakes. These are some of the most critical items on a motorcycle. Pay specific attention to the condition and air pressure in your tires. Make sure the wheels are free of cracks and dents and that the wheel bearings are serviceable. Check the front and rear brake for proper operation.
- Controls – Check all levers, pedals, cables and hoses. Look for any items that may be bent, broken, frayed or cracked. Check the throttle to ensure proper operation. It should move smoothly and snap closed when released.
- Lights – Inspect the headlight, taillight, brake light and turn signals for proper operation. This is also a good time to check that all reflectors, lenses and mirrors are secure and serviceable.
- Oil – Always check the engine oil level. Also check other fluids, such as gear oil, engine coolant and fuel levels. Make sure there are no fluid leaks.
- Chassis – Check the motorcycle's frame for any signs of cracks or other unsafe conditions. Ensure the suspension operates smoothly with the proper pre-load. Check the condition of the chain or belt. Make sure all fasteners are tight and free of corrosion.
- Stand – Inspect the side or center stand for any cracks or bends that can cause an unsafe condition.

Motorcycle safety should always be taken seriously. Riders are at a greater risk than other motorists while out on the road. Taking just a few minutes to conduct a pre-ride inspection can decrease the chances of mechanical failures and will ensure the proper performance of your motorcycle. This can help reduce some of the risks associated with riding and will improve your safety. Make a pre-ride inspection part of your normal routine.

Experience tells us that sometimes accidents happen when you least expect them. A motorcycle pre-ride inspection will help decrease the odds of you finding yourself in a mishap situation. Always remember to ride safely and arrive alive!



FYI

To print your own copy of a T-CLOCS inspection checklist, visit https://safety.army.mil/Portals/0/Documents/OFF-DUTY/PMV-2/PAMPHLETSCHECKLISTS/Standard/TCLOCS_2022.pdf. For additional information, visit https://safety.army.mil/OFF-DUTY/Motorcycles. ■

PRE-RIDE INSPECTIONS

COL. DARIN SCHUSTER
DELAWARE ARMY NATIONAL GUARD
NEW CASTLE, DELAWARE

THE HIDDEN RISK

Personal protective equipment (PPE) is essential for ensuring the safety of Soldiers conducting maintenance operations in Army motor pools. However, a concerning trend persists: combat-issued gear is regularly used in place of proper maintenance PPE — a practice that introduces unnecessary risk. While designed for battlefield conditions, combat equipment is not optimized for industrial hazards commonly encountered in garrison maintenance shop environments.

Despite existing safety regulations, substituting combat gear for shop PPE remains widespread due to availability, familiarity and leadership perceptions. This article examines the shortcomings of combat-issued PPE for maintenance work and provides actionable recommendations to mitigate injury risks, improve compliance and enhance operational readiness. What this article does not explore — but is worth noting — is the high frequency of accountable combat-issued equipment being damaged or lost, the financial burden placed on Soldiers, impacts on individual combat readiness and the unintended influence these factors have on individual PPE use avoidance.

Combat equipment vs. proper PPE

Combat gear prioritizes durability and protection in tactical environments but fails to meet the demands of industrial safety. Issued gloves, ballistic eyewear and ballistic helmets lack the specialized protections required for maintenance work. Key limitations include:

- Combat gloves: Reduced grip, minimal cut resistance and low chemical protection
- Ballistic eyewear: Insufficient shielding against grease, chemicals and high-intensity lighting compared to industrial goggles
- Ballistic helmet: Heavy, cumbersome and ineffective against typical shop hazards, such as falling objects or sparks

Despite these shortcomings, combat gear remains widely used in motor pools due to standardization, availability and cultural perceptions of adequacy. Many Soldiers and leaders consider the issued equipment "good enough" without realizing the risks associated with improper PPE use.

Increased injury rates and long-term health risks

Improper PPE use contributes to avoidable injuries that may appear minor but have long-term consequences. Reduced dexterity from combat gloves increases the likelihood of dropped tools and hand injuries, while inadequate eyewear exposes Soldiers to airborne debris and chemicals. Without proper protection against hazardous conditions, personnel may face chronic medical conditions appearing

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181st Infantry Brigade
U.S. Army Western Hemisphere Command
Fort McCoy, Wisconsin

over time. Army safety statistics indicate maintenance-related injuries rank among the top five non-combat mishaps across motor pools. Historical reports illustrate the correlation between inadequate PPE compliance and increased safety incidents, reinforcing the urgency for proper protective equipment.

Adopting industry-standard PPE

Equipping Soldiers with maintenance-specific PPE will mitigate risks, improve compliance and enhance operational safety. Recommended alternatives include:

- Shop gloves: Improved grip, cut resistance and chemical protection
- Safety goggles: Enhanced shielding against debris, fluids and welding hazards
- Hard hats: Lightweight helmets designed for industrial environments, reducing fatigue and offering better impact protection

Army regulations already outline PPE requirements for motor pool operations, but implementation remains inconsistent. Leadership must ensure that proper equipment is available, accessible and integrated into daily maintenance protocols.

Policy changes and leadership accountability

To reduce injuries and improve operational efficiency, Army leaders must enforce strict PPE policies, including:

- Mandatory PPE training for motor pool personnel
- Supply chain adjustments to ensure proper equipment distribution
- Leadership accountability in enforcing PPE standards

Conclusion

Proper shop PPE enhances both Soldier safety and equipment longevity, reducing unnecessary injuries and costs. By shifting the culture away from combat-issued gear for maintenance work, the Army can ensure readiness and risk reduction in motor pools across all units. ■

After an exhaustive training flight in the desert, the crew was pleased with what they accomplished. All that was left was to conduct their before-leaving-the-helicopter checks. What they didn't know was their biggest mistake of the night was about to occur.

With just four crewmembers present, the crew started towing the aircraft into the hangar to conduct postflight checks under better lighting conditions. Suddenly, they heard a loud, grinding noise coming from the left side and announced a halt to inspect the issue. The left-side crew chief, who was blade walking at the time, noticed the problem first. The Aircrew Combat Equipment vest leg strap, which was hanging over the gunner's window, had been pulled under the wheel and dragged, resulting in a gouge in the tire. Although there was no damage to the vest, the tire had to be replaced.

Towing aircraft is a routine process for most aviators. While this incident could easily be labeled as just a crew mistake, the truth is more complex. This event was a direct result of three human factors seen all too often in aviation mishaps — fatigue, failure to follow SOPs and time pressure.

Fatigue

Chapter 3 of Training Circular 3-04.93, Aeromedical Training for Flight Personnel, states that "stress and fatigue in flying operations adversely affect mission execution and aviation safety." This mishap occurred during the last one-third of the duty day. Impaired judgment, slower reaction times and decreased attention to detail were all factors of fatigue that affected the crew while they conducted what should have been a simple task. The crew chief never noticed the leg strap hanging out the window in front of the tire. Neither the brake rider nor the tow driver conducted a walk-around prior to towing the aircraft. Extra precautions must be taken during night operations. Fresh minds and sharp eyes could have prevented this mishap.

Deviation of standards

According to the unit's SOP, seven people are required to conduct towing operations. This procedure is written to provide awareness around the helicopter and catch issues that could cause a mishap. Everyone else in the unit had gone home for the day, and the crew fell into the mindset of, "We've done this a hundred times; we'll be OK." The decision to deviate from the standard introduced a hazard that could have been mitigated if the crew followed the SOP. While SOPs may seem overly cautious, they often account for unpredictable risks that have been mitigated through detailed processes.

Time pressure

The last causal factor in this mishap was a rush to complete the job — or "get-home-itis." After a long flight, postflight checks still needed to be conducted. The crew wanted to get this job done quickly so they could go home. Every aviator has experienced this, and we need to be aware of its effects on decision-making. The crew's decision to expedite this process led to failure of basic safety measures, resulting in damage to the helicopter.

Lessons learned

The mishap served as a stark reminder of the dangers of fatigue, deviating from SOPs and rushing to complete a job. This crew allowed fatigue to affect their decision-making. Then, by failing to follow the SOP, they introduced an unforeseen risk into the task of towing the helicopter. Finally, by trying to speed through the postflight inspection so they could get home earlier cost them even more time and effort when they damaged the aircraft tire. Following this mishap, the unit decided that any flight that finished after dark would terminate on a parking pad on the ramp. Implementing this process allows a rested crew, with enough tow team members, to reposition the aircraft under daylight, where they can conduct postflight maintenance checks without feeling rushed.

"Mishaps can occur anywhere. If you're tired and feel that cutting corners is a risk you're willing to accept, slow down and remember to follow the procedures."

In conclusion, Army aviation is built on rules and regulations that are put in place for a reason. Aviators must respect the effects of fatigue on their decision-making during every phase of an operation and never let complacency lead to rushed processes. Mishaps can occur anywhere. If you're tired and feel that cutting corners is a risk you're willing to accept, slow down and remember to follow the procedures. Your crew, the aircraft and the mission deserve nothing less. ■

A Tired TOW Team

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Fort Campbell, Kentucky

A few years ago, I received a phone call from my youngest brother. He was going to preach at the church where my grandparents have been members of most of their adult lives. The service would take place in Greeneville, Tennessee, about 500 miles from my home in Enterprise, Alabama. I decided not only to attend, but to ride my motorcycle there.

DRESS for the SLIDE, NOT the RIDE

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The day before I was to leave, I inspected my bike and personal protective equipment (PPE). I noticed the Kevlar in my jacket was deteriorated and the face shield on my full-face helmet was scratched badly. It was too late to get a new face shield, so I bought a new jacket and helmet that evening. This would be the first time I'd ridden more than 300 miles and I wanted to be as safe as possible.

I came home and finished packing the bike, ensuring the load was balanced, before going to sleep about 10 p.m. The next morning, I woke about 8 a.m., got dressed and inspected my bike once again. I then rode to the local Huddle House restaurant to eat a good breakfast before my long trip.

I made my first stop at a gas station just outside Montgomery. There, I called my wife, who was in Texas visiting family, and checked in with a friend to let them know where I was on my route. From that point on, I took a break at either a rest area or gas station every two hours, each time phoning my wife and friend. On two of those stops, I was tempted to remove my jacket due to the slight rise in temperature, but I resisted the urge both times. I knew if I was to get into an accident, the jacket would save me some skin.

About 5 p.m., I entered Knoxville, Tennessee, on I-40 East, about 50 miles from my final destination. There was construction on the left side of the road, and vehicles in all four lanes of traffic were traveling about 50-60 mph. I was riding with the speed of traffic in the far left-hand lane when I felt my rear tire slide. I corrected the bike and then my front tire started to wobble, which caused my motorcycle to slide out from under me. As I laid the bike down, I pushed myself away as it slid toward the direction of traffic. Fortunately, I managed to roll my body into the left-hand median.

Some guys ran over to offer assistance. They helped me to my feet, but they would not let me take off my helmet for fear I may have an unseen injury. I noticed some other good Samaritans pick up my bike and move it to the right-hand side of the road. One of them also handed me my phone. I was still feeling a bit frazzled, so I asked him to call my wife for me.

Once I was safely on the side of the road, an ambulance arrived. When one of the paramedics saw me walking around, she smiled and said, "You were dressed for it." This was the first motorcycle accident she'd responded to where the rider got up and walked away. She then told me to take off my helmet and look at it. The right side had an 8- to 10-inch scrape from the middle of the forehead to the back-right side. The face shield had a 4-inch scrape down the top-right side. Had I been wearing a half helmet, I probably would be dead. My only injuries were a scraped left knee and some minor road rash.

I have no doubt that several factors allowed me to walk away from the mishap, the first being my training. The training I received in the Motorcycle Safety Foundation's Basic RiderCourse and Advanced RiderCourse taught me to prepare for a mishap. Riding two wheels demands risk analysis at every step and taking measures to reduce the hazards, including being properly trained and prepared.

Second, I conducted multiple pre-inspection checks before I started my trip. These inspections are paramount to safe riding. Remember to not only check out your bike, but also your riding gear, helmet, gloves and jacket. When I noticed my jacket and helmet's face shield were unsafe, I replaced them.

Third, I had an effective ride plan. I ensured I stopped for a break every few hours to stretch and prevent fatigue. I also made sure to check in with my wife and friend on those breaks. Discussing your route and estimated check-in times allows others to know when you expect to arrive at your destination. If something were to happen, such as a crash, those people could tell authorities your last known location.

Finally, the PPE I wore on this ride was the true hero of this story. I have a friend I often ride with who constantly says, "Dress for the slide, not the ride." That's exactly what I did. I will never ride without a Department of Transportation-approved full-face helmet, riding jacket and gloves. And while I was tempted to remove my jacket due to the rising temperature, I kept it on because I knew it would protect me if I was involved in a mishap. I realize PPE can't protect me from all of the dangers related to riding on two wheels, but it will enhance the chances of surviving a crash.

FYI

For more information on safe riding, visit the USACRC's motorcycle safety page at https://safety.army.mil/OFF-DUTY/Motorcycles. ■

I grew up in southern Arkansas, fishing backwater lakes for pan fish, crappie, smallmouth bass and catfish. As a youngster, I cut my teeth on several different aluminum jon boats my dad owned over the years. These early boats had a few things in common: they were all 14 feet long, narrow and equipped with a small outboard motor. Fast forward several years and I was looking to purchase my first fishing boat. I opted for a shorter but wider model than I grew up with, settling on a 12-foot-long, 36-inch-wide jon boat. Being a red-blooded, southern-American male, it should be no surprise that I also purchased the largest outboard motor rated for the boat. The salesman offered to have the outboard set up and mounted — for a small fee, of course — but I declined. After all, I grew up in a jon boat and installed outboard motors dozens of times.

BOATING INTO THE BANK

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Joint Force Headquarters
Arkansas Army National Guard
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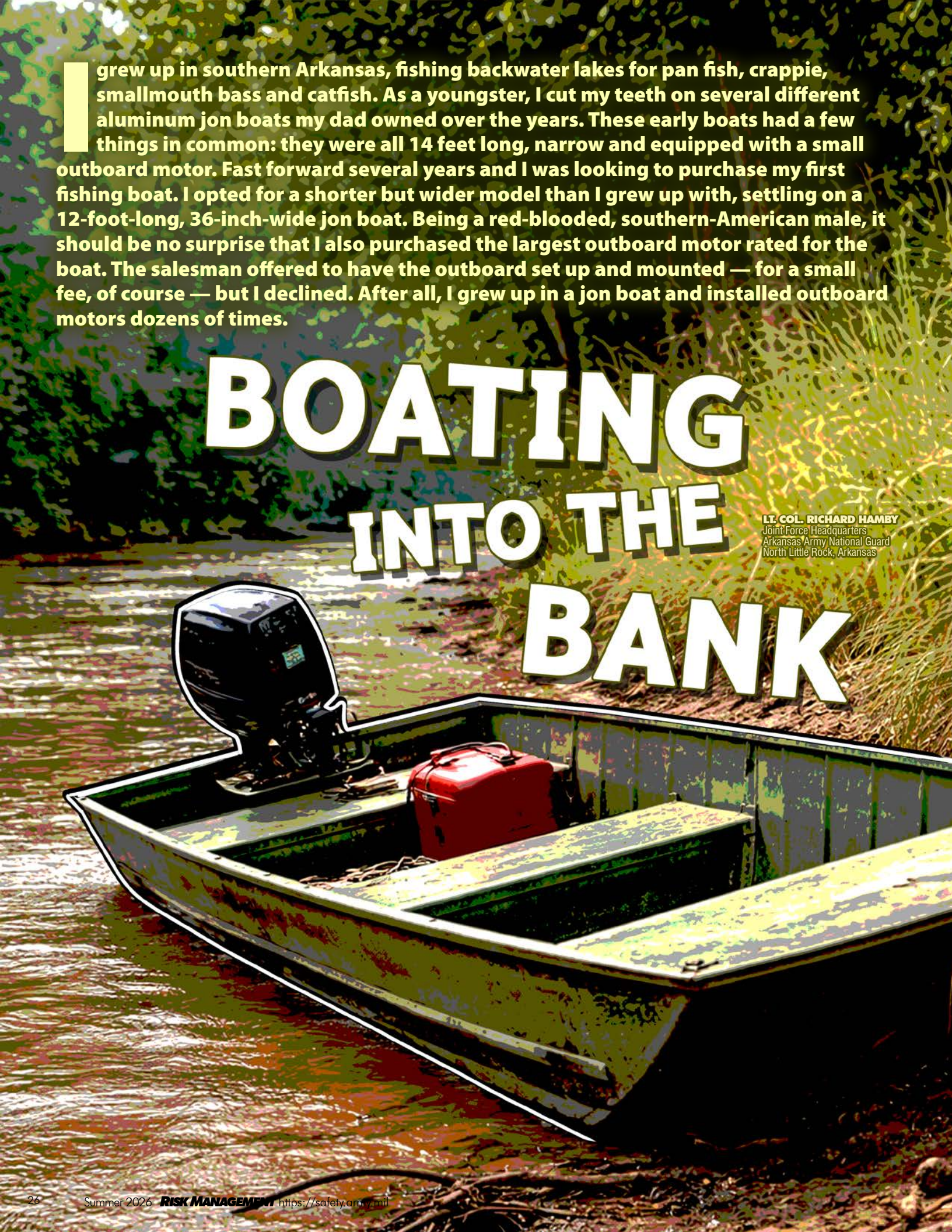


The next day was a bluebird, mid-April morning. I mounted the outboard on my new boat, checked the fluids and headed out for the water. After I launched the boat into the Red River, I checked the engine throttle and worked my way through shifting gears. I then headed upriver so I could float back down to the boat ramp if I encountered any issues. Right away I noticed each time I rolled the throttle up on the tiller arm to increase acceleration, the bow of the boat would rise up higher than expected. In fact, it was high enough that it blocked my view of where I was going. As the boat picked up speed, however, the bow leveled without issue.

I continued upriver, stopping from time to time to inspect the boat and enjoy the day. Each time I started again, the bow rose up and blocked my view before leveling out again. I traveled about 2 miles to the low-water dam, where I turned the boat around, opened the throttle wide open and headed back down river.

I was flying down the middle of the river with the wind in my face. (Actually, I was only running about 15 mph, but in a 12-foot boat, it seemed much faster.) The only thing in the water was the outboard's propeller — at least that's what it felt like. The river was relatively smooth and the boat was skipping along, the bow bouncing lightly off the surface. I was the only one out and it was great. Continuing down river, I turned the boat with the bend and into the wind. That's when it happened.

Without warning, a strong gust of wind lifted the bow straight up and, in a blink of an eye, I was looking at blue sky. The boat spun 90 degrees before the front end dropped and I realized I was headed straight for the riverbank still running wide open. I had enough time to release the tiller arm, grab the sides of the boat and hang on for dear life.

Fortunately, the muddy riverbank gently sloped upward. As the boat slid halfway up the bank, I hurdled the seats and landed in the mud. As I stood there in front of my boat, I took a few minutes to survey the situation. The boat and motor were both OK and, luckily, so was I. I'd dodged a bullet. I eased the boat back into the water, cinched up my life jacket, hooked the outboard's kill switch tether line to my belt loop and continued down river — this time at a much slower speed. Once I reached the boat landing, I loaded up and headed home.

On this day, a lot of little issues aligned to create a dangerous situation. I'd set up the outboard motor improperly, which created a downward force on the stern and rose the bow. As the boat bounced off the water, an unexpected wind gust lifted the bow ever higher, sending me out of control into the riverbank. It was the classic Swiss cheese model of accident causation.

The moral of this story is there is a right way to set up an outboard motor, even on small jon boats. Make sure to read your outboard owner's manual to ensure you set up yours properly. In case you didn't know, the cavitation plate, that horizontal fin just above the propeller, should be mounted to the lower unit of the boat. In addition, always wear an appropriate U.S. Coast Guard-certified life jacket any time you go out on the water and ensure you attach the outboard's kill switch tether cable to your person. Most importantly, always operate your boat responsibly. If you're one of those people who is less concerned about proper setup, I recommend you carry along a small shovel in your boat. It will come in handy when you have to dig your tennis shoes out of the sticky mud. Boat safely! ■

SECOND-QUARTER FY26 MISHAP BRIEFS

ON-DUTY FATAL MISHAPS

GMV

- A 27-year-old Specialist assigned to the National Training Center, Fort Irwin, California, died in a government motor vehicle mishap 23 February 2026 on the installation at 1314 local. The Soldier was ground guiding a vehicle when he was pinned between it and another vehicle. Emergency medical services personnel responded promptly to the scene, initiated CPR and transported the Soldier to a local hospital, where he died.

OFF-DUTY FATAL MISHAPS

PMV-4

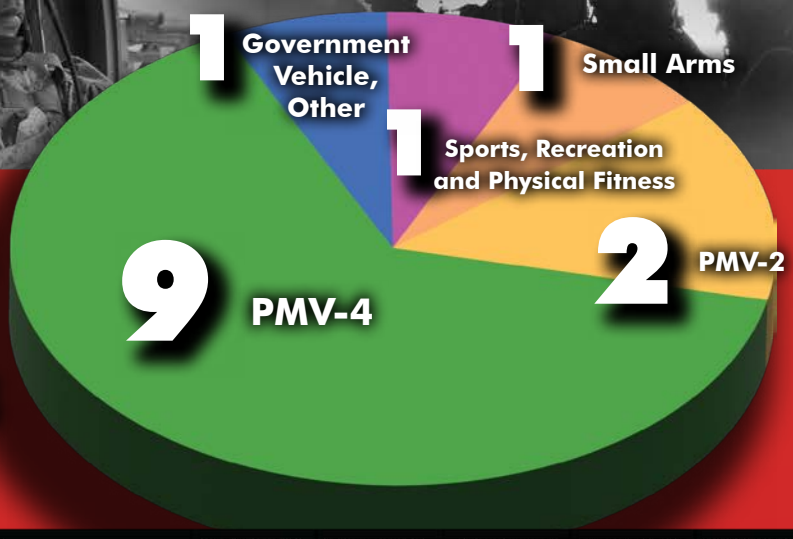
- A Private First Class assigned to Fort Stewart, Georgia, died in an automobile mishap 3 January 2026 in Colorado at 1245 local. The Soldier was on leave when the vehicle he was riding in crashed.

- A 22-year-old Specialist assigned to U.S. Army Reserve Center, Orangeburg, New Jersey, died in an automobile mishap 11 January 2026 in Alpine, New Jersey, at 0600 local. The Soldier, who was on active orders but off duty at the time of the mishap, sustained fatal injuries when his vehicle veered off the highway during low-visibility conditions and crashed. Emergency responders pronounced the Soldier dead at the scene.

- An 18-year-old Private Second Class assigned to 3rd Brigade Combat Team, 10th Mountain Division, Fort Polk, Louisiana, died in an automobile mishap 31 January 2026 in Denham Springs, Louisiana, at 0014 local. The Soldier's vehicle collided with a truck on the highway and rolled into a ditch. Emergency services were called, and the Soldier was pronounced dead at the scene.

- Two Specialists assigned to 1st Brigade Combat Team, 82nd Airborne Division, Fort Bragg, North Carolina, died in an automobile mishap 14 February 2026 in Sanford,

SECOND-QUARTER ARMY MILITARY MISHAP FATALITIES



TOTAL: 31

as of 29 Apr 26

CATEGORY	1STQTR	2NDQTR	3RDQTR	4THQTR	TOTAL YTD
GMV	1	0			1
Government Vehicle, Other	2	1			3
PMV-2	6	2			8
PMV-4	6	9			15
PMV-Pedestiran/Non-Motorist	1	0			1
Sport, Recreation and Physical Fitness	1	1			2
Small Arms	0	1			1
TOTAL	17	14			31

North Carolina, at 0330 local. The Soldiers' vehicle collided head-on with a pickup truck. A third Soldier in the vehicle was critically injured and airlifted to Womack Army Medical Center.

- A 26-year-old Private First Class assigned to 1st Cavalry Division, Fort Hood, Texas, died in an automobile mishap 7 March 2026 near Florence, Texas, at 0200 local. The Soldier was traveling back to Fort Hood in a private motor vehicle with two other Soldiers when they were involved in the mishap. The other Soldiers received minor injuries.

- A 20-year-old Specialist assigned to 1st Cavalry Division, Fort Hood, Texas, died in an automobile mishap 16 March 2026 near Cameron, Texas, at 0500 local. The Soldier was involved in a two-vehicle mishap while returning from leave.

- A 35-year-old Sergeant First Class assigned to the Army Interagency Training and Education Center, West Virginia, died in an automobile mishap 16 March 2026 in West Virginia at 1430 local. The Soldier was driving on Interstate 77 at the time of the single-vehicle mishap. Emergency medical services personnel responded to the scene and transported him to Jackson General Hospital, where he was pronounced dead.

PMV-2

- A Private First Class assigned to Fort Irwin, California, died in a motorcycle mishap 27 January 2026 in Baker, California, at 2200 local. The Soldier lost control of his motorcycle on Interstate 15, resulting in severe head trauma and multiple fractures. He was airlifted to University Medical Center in Las Vegas, where he later died. The Soldier reportedly had not completed the Motorcycle Safety Foundation's Basic RiderCourse and did not possess a motorcycle endorsement on his civilian driver's license.

- A 35-year-old Staff Sergeant assigned to 302nd Military Intelligence Battalion, Fort Campbell, Kentucky, died following a motorcycle mishap 28 February 2026 near the installation at 1815 local. The Soldier was riding a neighbor's motorcycle when the mishap occurred. He was airlifted to Skyline Medical Center in Nashville, Tennessee, where he later died.

DRESS FOR THE SLIDE ... NOT THE RIDE

AT A MINIMUM, PROPER PPE INCLUDES:

- Department of Transportation (DOT)-certified helmet
- Impact- or shatter-resistant goggles or a properly attached full-face shield
- Sturdy, over-the-ankle footwear
- Long-sleeved shirt or jacket
- Long trousers
- Full-fingered gloves or mittens made of leather or abrasion-resistant material

SPRING INTO SUMMER
READY MISSION STEADY!

REMEMBER, GOOD GEAR IS WORTH EVERY DIME, EVERY TIME.

U.S. ARMY

https://safety.army.mil

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- Leverages external authoritative data from agencies across DoD to proactively aid leaders and SOH personnel to target loss prevention and preservation of resources.
- Provides on- and off-line capabilities that surpass current systems in robustness and ease of use.
- Includes streamlined applications with less burdensome data entry, intuitive step-by-step guidance and fewer required data points that will result in lower reporting times.
- Will do away with paper mishap forms.
- Provides innovative offline capability that allows users to work without network connectivity, eliminating the need for software installation on a computer. Data syncing upon re-establishment of connectivity requires only a mouse click.

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