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RM QUARTERLY

AUTUMN 2026

# RISK MANAGEMENT

OFFICIAL SAFETY MAGAZINE OF THE U.S. ARMY

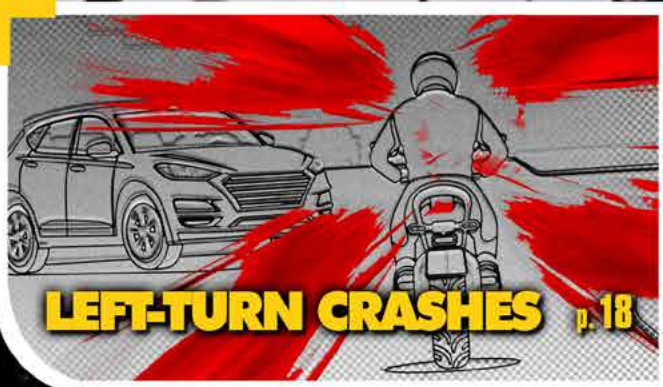
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RISK MANAGEMENT
LEADERS SOLDIERS CIVILIANS FAMILIES
AUTUMN 2026

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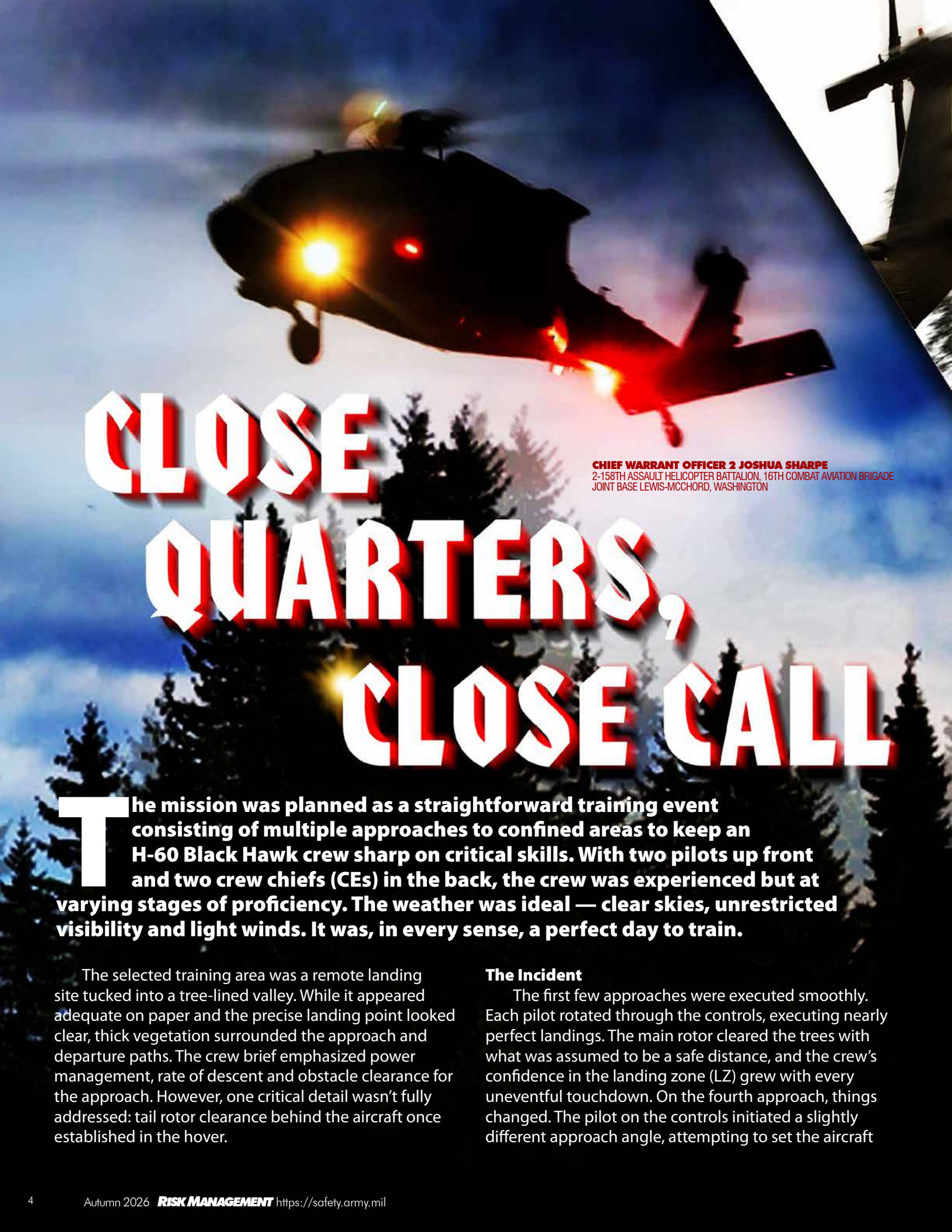
## MISSION STATEMENT:

***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.***

U.S. ARMY

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# CLOSE QUARTERS, CLOSE CALL

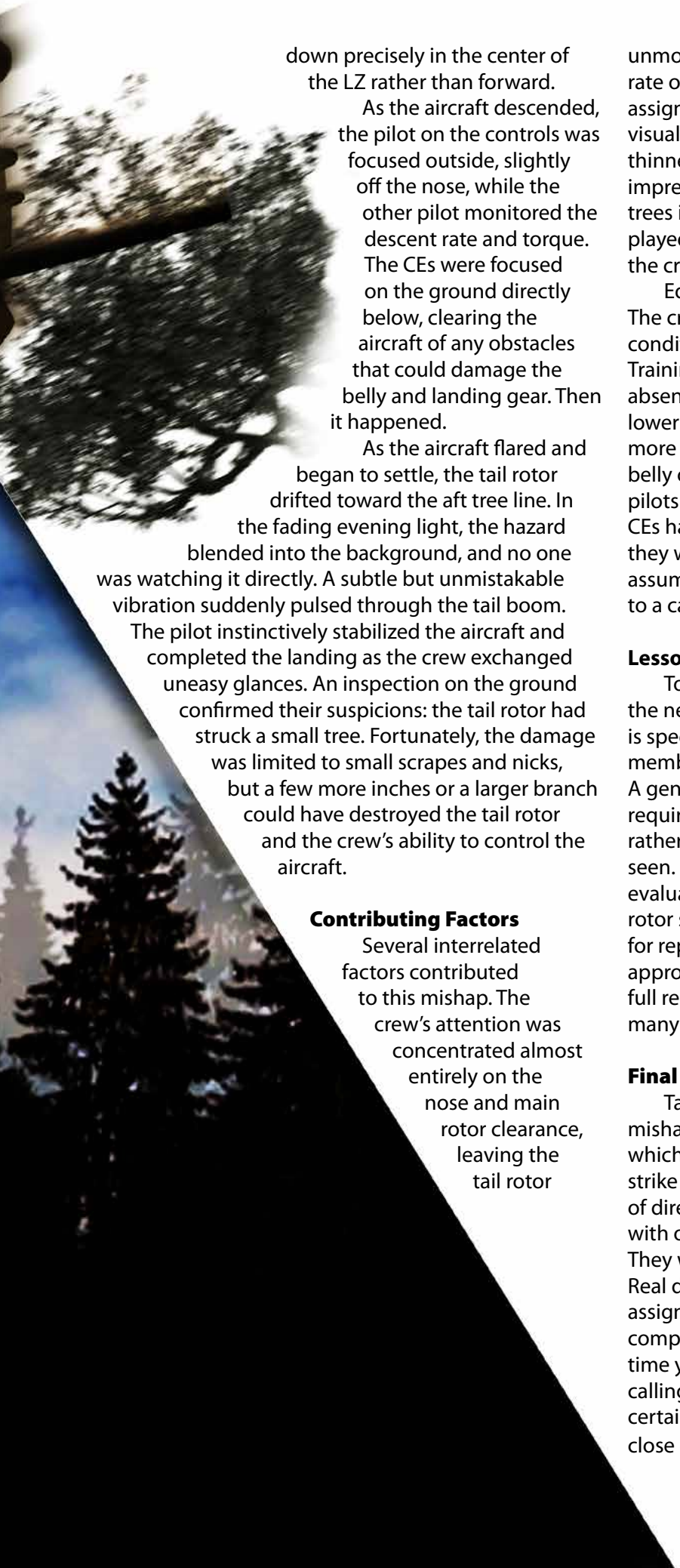
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**The mission was planned as a straightforward training event consisting of multiple approaches to confined areas to keep an H-60 Black Hawk crew sharp on critical skills. With two pilots up front and two crew chiefs (CEs) in the back, the crew was experienced but at varying stages of proficiency. The weather was ideal — clear skies, unrestricted visibility and light winds. It was, in every sense, a perfect day to train.**

The selected training area was a remote landing site tucked into a tree-lined valley. While it appeared adequate on paper and the precise landing point looked clear, thick vegetation surrounded the approach and departure paths. The crew brief emphasized power management, rate of descent and obstacle clearance for the approach. However, one critical detail wasn't fully addressed: tail rotor clearance behind the aircraft once established in the hover.

## The Incident

The first few approaches were executed smoothly. Each pilot rotated through the controls, executing nearly perfect landings. The main rotor cleared the trees with what was assumed to be a safe distance, and the crew's confidence in the landing zone (LZ) grew with every uneventful touchdown. On the fourth approach, things changed. The pilot on the controls initiated a slightly different approach angle, attempting to set the aircraft



down precisely in the center of the LZ rather than forward.

As the aircraft descended, the pilot on the controls was focused outside, slightly off the nose, while the other pilot monitored the descent rate and torque. The CEs were focused on the ground directly below, clearing the aircraft of any obstacles that could damage the belly and landing gear. Then it happened.

As the aircraft flared and began to settle, the tail rotor drifted toward the aft tree line. In the fading evening light, the hazard blended into the background, and no one was watching it directly. A subtle but unmistakable vibration suddenly pulsed through the tail boom. The pilot instinctively stabilized the aircraft and completed the landing as the crew exchanged uneasy glances. An inspection on the ground confirmed their suspicions: the tail rotor had struck a small tree. Fortunately, the damage was limited to small scrapes and nicks, but a few more inches or a larger branch could have destroyed the tail rotor and the crew's ability to control the aircraft.

## Contributing Factors

Several interrelated factors contributed to this mishap. The crew's attention was concentrated almost entirely on the nose and main rotor clearance, leaving the tail rotor unmonitored. While the crew thoroughly briefed power, rate of descent and main rotor clearance, they failed to assign explicit responsibility for tail rotor monitoring. A visual illusion further complicated the situation, as the thinner vegetation behind the aircraft created a false impression of ample clearance compared to the denser trees in front. Furthermore, cumulative complacency played a role, as three prior successful landings lowered the crew's vigilance by the fourth approach.

Equally important were the human factors in play. The crew was confident, rested and operating in good conditions, but that confidence itself became a hazard. Training environments often feel forgiving, and the absence of stressors like poor weather or fatigue can lower risk awareness. The CEs later admitted they were more focused on the ground hazards directly below the belly of the aircraft than on the tail rotor, assuming the pilots were accounting for it. The pilots assumed the CEs had a clear line of sight with the tail rotor and that they were monitoring it. Ultimately, dangerous mutual assumptions created a critical blind spot that almost led to a catastrophe.

## Lessons Learned

To prevent similar mishaps, this incident highlights the necessity of explicit duties where tail rotor clearance is specifically briefed and assigned to at least one crew member who must provide positive visual confirmation. A generic "clear left, right, tail" is insufficient. Coordination requires active communication and explicit confirmation rather than the assumption that a hazard has been seen. Additionally, crews must conduct a total footprint evaluation during LZ selection, ensuring that the entire rotor system — not just the aircraft body — is cleared for repositioning, hovering and departing. Finally, every approach must be treated as its own event, requiring a full reevaluation of hazards each time, regardless of how many successful landings were previously completed.

## Final Assessment

Tail rotor strikes are among the most dangerous mishaps in Army aviation. Unlike a main rotor strike, which may allow for limited flight control, a tail rotor strike often results in immediate and unrecoverable loss of directional control. In this case, the crew walked away with only a scarred rotor system and bruised confidence. They were lucky, but luck is not a mitigation strategy. Real defense lies in disciplined communication, clear assignments and a conscious effort to guard against complacency — especially on the "easy" days. The next time you enter a confined area, ask yourself: "Who's calling the tail clear?" If the answer isn't immediate and certain, you're setting yourself up for more than just a close call. ■

# ALWAYS EXPECT THE

**The date was April 26, 2023. I was TDY and had just returned to my hotel room after having dinner with a co-worker. About 7:45 p.m., I received a phone call from a number I did not recognize. I answered it anyway. The person on the other end of the line identified herself as a representative from Harborview Medical Center in Seattle and explained she obtained my number from one of their patients. That was the moment I knew something terrible had happened and it wasn't going to end well.**



**CHIEF WARRANT OFFICER 5 JAMES JOHNSON**
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My son, Mike, had recently returned from an overseas tour and was staying with us. He was eager to get back on his motorcycle, but because it had been sitting, the bike needed some work first. On Monday, April 24, Mike and I spent the day servicing and repairing his motorcycle. By the end of the day, it was serviced, leak-free and ready to ride.

Mike didn't have to go into the office that week due to a requirement to complete some distance learning courses. He must have finished his work early because he decided to go for a ride. Mike was a disciplined rider and always wore leather chaps, gloves, safety glasses and a half helmet. He was several miles from the house when he turned right onto a four-lane road with a center turn lane.

After traveling about a quarter-mile, Mike turned right again and switched to the left lane, where he encountered a pickup truck pulling a boat in a parking lot adjacent to the road. The pickup driver didn't see Mike, and Mike didn't see him. As Mike approached, the pickup pulled out, turning left directly in front of him. The truck and boat now obstructed both lanes. Mike, positioned in the left lane, took immediate corrective action by steering toward the center turn lane. However, the truck did not stop, effectively blocking any remaining escape route. Mike laid his bike down to try and reduce the force of the collision, but due to the speed of both vehicles, the slide did little to mitigate the impact. He struck the truck's bumper face-first.

First responders arrived quickly and assessed Mike's injuries, which were life threatening. A LifeFlight helicopter was dispatched to the accident site and transported him to Harborview Medical Center — a facility renowned for trauma care. I



# UNEXPECTED

was told later that the LifeFlight crew resuscitated him during the trip to Harborview, but he was placed on life support immediately upon arrival.

Mike's mother, sisters and my wife were able to see him that evening. My last words to my son were spoken over a cellphone held to his ear by my wife. He was removed from life support a short time later. In his final act of service, Mike saved several lives by donating his organs.

In retrospect, almost the same exact situation happened to me 30-plus years ago. I had turned right at an intersection and moved from the right lane to the left when a Volkswagen van pulled out from a parking lot, turning left in front of me. Like Mike, I had only been on the road for a short distance, limiting the driver's time to see me. In my case, I was able to walk into the emergency room to be evaluated; my left hand was broken in two places. At the time, I was wearing a leather jacket, gloves and a full-face helmet.

Mike was an experienced rider with years of time in the saddle; I was an "indestructible" 20-year-old. Both of our motorcycles were well-maintained, and we both wore personal protective equipment routinely. Like many Harley-Davidson riders, Mike preferred a half helmet. I've asked myself: Would a full-face helmet have saved his life? After reviewing the video provided by the police, I think the answer is no. Mike hit the corner of the front bumper face-first with all his momentum.

We plan for what we can control. We maintain our vehicles, ensure we are well-rested, avoid distracted driving and practice situational awareness to the best of our abilities. We stress these concepts during every safety brief for long weekends and convoys. I have heard these words hundreds of times throughout my career. Unfortunately, drivers on the road today are simply not paying enough attention. Motorcycle riders must remain on high alert at all times, expecting the unexpected. Even then, we cannot predict every variable. We must remain absolutely vigilant at all times, regardless of what we are driving or riding. Our lives depend on it. ■

# NO ROOM FOR ERROR

**DON WINNINGHAM, PCESII, CSHO**
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**In any complex environment, the pressure of a high operational tempo (OPTEMPO) and the urgency of critical mission requirements can create a powerful temptation to sideline established safety standards. The mission-first mindset, while essential for success, is often misinterpreted as a justification for cutting corners on procedures that seem cumbersome or time-consuming. This perspective, however, is a dangerous fallacy. Regulations, policies and safety procedures are not arbitrary obstacles to efficiency; they are the bedrock of operational integrity. Adherence to these standards is most critical precisely when the pressure is highest, as it provides a disciplined framework that prevents costly errors in judgment and execution under stress.**

This principle is magnified exponentially in the world of ammunition and explosives (A&E) management, where the unforgiving nature of energetic materials leaves no room for error. The demand to quickly build, transport and issue munitions for a critical operation might tempt personnel to bypass seemingly redundant checks, such as verifying storage compatibility groups, confirming proper equipment grounding or double-checking shipping documentation. However, these safety standards are lifesaving controls written from the hard-earned lessons of past incidents. A single deviation — a missed inspection, an incorrect fuze setting or an overlooked placarding requirement — can be the sole catalyst for a catastrophic event, leading to mass casualties and total mission failure before it even begins.

While some deviations are born from pressure or haste, a far more dangerous scenario arises when safety standards are intentionally disregarded. This often stems from a hazardous combination of overconfidence and a cultural normalization of deviance, where repeated, small-scale violations without immediate negative consequences create a false sense of security. An individual or a team may come to believe their experience allows them to know better than the regulation, viewing established procedures as bureaucratic red tape rather than essential controls. This intentional violation is not a calculated risk; it is a gamble with the lives of everyone involved. It fosters a corrosive command climate where official policy is seen as optional, systematically dismantling the layers of defense designed to prevent the very worst outcomes.

Ultimately, safety and mission accomplishment are not opposing forces; they are inextricably linked. Disregarding established protocols — whether through haste or hubris — does not expedite the mission; it introduces unacceptable risks to the most critical asset: personnel. An accidental detonation at an installation ammunition supply point, depot or arsenal not only results in loss of life but also destroys the very assets intended for the fight, creating a logistical crisis and crippling operational readiness. True operational effectiveness is achieved not by circumventing standards, but by integrating them so thoroughly that they become second nature. In the realm of A&E, there is no distinction between operational effectiveness and safety. The mission is only accomplished when it is accomplished safely.

To ensure the integrity of our A&E operations and to protect the force, the following standards must be strictly observed without exception:

**Do**

- Integrate safety: Treat safety as an integral part of every operational plan and action.
- Lead by example: Enforce standards from the top down and demonstrate unwavering commitment to safety.
- Empower personnel: Foster a climate where anyone can and should halt an unsafe act without fear of reprisal.
- Understand the "why": Educate personnel on the reasons behind the regulations to build buy-in and professional knowledge.

**Don't**

- Cut corners: Never allow urgency or pressure to justify bypassing a required safety check or procedure.
- Normalize deviance: Do not tolerate small, repeated standards violations, as they breed complacency and lead to catastrophic failure.
- Mistake experience for immunity: Do not allow overconfidence or experience to serve as a substitute for following established procedures.
- View safety as an obstacle: Never treat safety regulations as "red tape" to overcome. View them as essential tools for mission success. ■

# WALK AWARE

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**Pedestrian safety feels simple because most of us learned the basics when we were young. Many Soldiers believe they fully understand the risks of being a pedestrian, especially when they are off duty. I learned how wrong that assumption can be one winter night in Henrico County, Virginia.**

A few years ago, a Soldier close to me — whom I will call Paul — attempted to cross a street at about 8:15 p.m. The area was extremely dark, and street lighting along that stretch was almost nonexistent. A vehicle struck him and fled the scene. Paul did not survive.

In the days following the tragedy, workers from nearby businesses noted that the stretch of road felt dangerous even during daylight. Many remarked that they dreaded crossing it because drivers rarely slowed down. These comments showed that the hazard was well known long before the accident, yet it took a life-changing tragedy to force a re-evaluation of how dangerous a routine walk can actually be.

Soldiers spend a massive amount of time managing risk during duty hours. We brief hazards, rehearse tasks and check equipment before every mission. However, many of us relax that disciplined mindset the moment we leave work, creating a dangerous gap in situational awareness. According to the U.S. Army Combat Readiness Center's annual assessment of the Army Safety Program, the vast majority of Soldier fatalities occur off duty. Over the last five years 60% of pedestrian fatalities occurred at night. These sobering trends show that off-duty hazards deserve the same respect and planning as on-duty tactical risks.

The night Paul was struck, he crossed a busy section of the road that locals described as difficult to navigate. Emergency responders diverted traffic while investigators examined the scene for evidence. When I learned the

details, I thought about how often I crossed roads the same way. I trusted that drivers would see me and assumed that nothing bad would happen. Those assumptions replaced awareness, which is a common cause of pedestrian mishaps. Even simple actions require deliberate attention to avoid preventable harm.

Several recurring hazards appear in pedestrian incidents across the country. Low visibility remains a primary danger, making pedestrians nearly impossible for drivers to spot in the dark, especially when wearing dark civilian clothing. This is compounded by distracted driving, which continues to rise as motorists look at mobile phones, navigation systems and in-car screens. Pedestrians also create danger for themselves through distracted walking, often by looking at their phones or wearing headphones near traffic. Additionally, mid-block crossings increase risk because drivers expect pedestrians at designated intersections, not between blocks. Finally, excessive vehicle speeds drastically reduce a driver's reaction time and exponentially increase the severity of any impact.

Soldiers can reduce their risk of off-duty mishaps by applying the same tactical discipline they use in uniform to their everyday lives. Pedestrians can easily increase their visibility by wearing reflective gear, carrying a flashlight or utilizing a phone light when walking along roads at night. It is also critical to use designated crossings, crossing only at marked crosswalks and intersections where drivers expect pedestrian activity.

Maintaining complete alertness by avoiding screens and headphones while near traffic is equally vital. Walkers should always walk defensively, assuming drivers do not see them, and wait for vehicles to completely stop before stepping into the road. Lastly, anticipating mistakes from motorists, such as drivers running red lights or turning without looking, helps prevent accidents before they occur.

Paul's death taught me that pedestrian safety requires constant vigilance, both on and off duty. The dangers we face in civilian clothes are just as lethal as the hazards we face in uniform. We routinely prepare for complex military operations, yet we easily overlook the simple risks found in everyday situations. Sharing this story serves as a reminder to all Soldiers that simple, routine actions can carry irreversible consequences. A few seconds of deliberate attention can prevent a lifetime of regret. Stay alert, maintain your situational awareness and protect yourself.

# DID YOU KNOW?

**According to U.S. Army Combat Readiness Center statistics, over the past five years, 20 Soldiers died in pedestrian mishaps, averaging four fatalities per year. The majority of these incidents occurred during hours of darkness, and alcohol was a known or suspected factor in nearly half of the cases. Nothing can be done for these Soldiers, but you don't have to join them in the Preliminary Loss Reports. Here are some safety tips for when you're traveling on foot:**

- **Always walk on the sidewalk. If there is no sidewalk and you must walk in the roadway, always walk facing traffic.**
- **Dress to be noticed by motorists. Wearing bright or light-colored clothing helps drivers see you. Reflective clothing is best but never assume drivers can or have seen you.**
- **Cross streets only at marked crosswalks or intersections.**
- **If crossing a multilane roadway, pedestrians should visually clear each lane as they proceed.**
- **If a car is parked where you are trying to cross, look for other drivers who may be pulling out and not see you because they are looking for traffic.**
- **Remember that telephone poles, utility boxes and parked vehicles block an oncoming driver's ability to see you.**
- **Look LEFT – RIGHT – LEFT in countries like the United States, where motorists drive on the right side of the street. In nations where drivers use the left side of the road, look RIGHT – LEFT – RIGHT prior to entering the street.**
- **Give drivers ample time to stop before entering the crosswalk.**
- **Crossing at locations with traffic signals helps motorists see you.**
- **Wearing headphones while walking, jogging, bicycling or riding a motorcycle on post is prohibited. If you choose to wear headphones off post, always remove them while crossing the street so you can hear approaching traffic.**
- **Always hold a child by the hand while crossing a street. Remember, walk — don't run.** ■

# LOWERING THE BOOM

**Let me tell you a story about how "get-there-itis" and a little bit of exhaustion can turn a hero move into a $150,000 nightmare in about four seconds flat. If you have spent any time on a flight line in the sandbox — specifically Afghanistan — you know the vibe. It is 110 degrees, the dust is in your teeth and the sound of the radio is a constant, urgent hum in the background. We were supporting troops in contact (TIC), which means our brothers on the ground were pinned down and taking fire. When a TIC pops off, the energy on the flight line changes instantly. It is no longer just "fixing a bird." It is a frantic race to save lives, where every second feels like an hour.**

Enter our crew chief. This guy was a total pro — one of those AH-64 maintainers who lived and breathed his MOS. But there was a major problem: he had been on his feet, working, for 18 straight hours. When you hit that 18-hour mark, your brain is no longer your own. It operates through a thick fog where reflexes drop to half-speed and logic turns to mashed potatoes. Your ability to properly assess risk is one of the very first things to go.

The crew chief was supposed to be done for the day, but he saw the oncoming shift struggling with a blade pin reset on an Apache. A blade pin is a massive, high-strength metal bolt that locks the main rotor blade into the hub. It is a critical component. If that pin is not set perfectly, that multimillion-dollar aircraft is just an expensive paperweight.

Driven by the urgent need to get that bird in the air, the crew chief made the fateful decision to help. He jumped into the compact crawler crane — commonly called a spider crane — to assist. These machines look like a robotic spider with four legs and a long telescoping arm, making them perfect for tight spaces on a flight line. He drove it out to the aircraft, feeling that mission-first adrenaline masking the fact that he was dead tired.

Here is where the story takes a turn. The crew chief hit the switch to extend the



NAME WITHHELD BY REQUEST

outriggers, the four stabilizing legs that keep the crane from tipping. This specific piece of gear has a critical safety design quirk: the spider crane has a safety sensor that knows if the legs are extended outward, but it gives absolutely no warning if they are not actually lowered and bearing weight on the ground. In his 18-hour-deep brain fog, our crew chief saw the legs were extended and figured he was good to go. He did not take the extra few seconds to physically confirm they were planted. He started to extend the long crane boom arm over the Apache's main rotor blade to get into position.

As soon as that heavy boom arm moved away from the crane's center of gravity, physics took over with brutal efficiency. Without the outriggers anchored to the earth, the crane had no balance. The whole machine groaned, tilted and crashed. The sound of a crane boom collapsing onto a composite rotor blade is something you never forget. It is not a metallic ding; it is a sickening, expensive snap that echoed across the entire flight line.

That single, fatigue-driven mistake caused $150,000 in damage. But the real cost? That Apache stayed on the ground. The ground troops did not get their air support from that tail number because someone was too tired to notice the kickstand was not down.

So, how do we stop this from happening to you or your buddies?

- Kill the hero myth: Staying up for 18 hours does not make you a better Soldier; it makes you a liability. Fatigue is an active hazard, plain and simple, just like an improvised explosive device. You would not walk into a minefield blindfolded, so do not operate heavy machinery when you can barely keep your eyes open.
- Enforce tactical patience: Even during a high-stakes TIC, rushing maintenance is a recipe for disaster. Taking the extra 30 seconds to conduct a proper walk-around of the crane to kick the outriggers would have saved $150,000 and, more importantly, kept that aircraft in the fight. Slow is smooth, and smooth is fast.
- Check your buddies: If you see a teammate 18 hours into a shift, have the courage to tell them to go hit the rack. The mission depends on us being sharp, not just being present.

**Lessons Learned**

Adrenaline cannot replace sleep, and passion cannot override physics. In high-OPTEMPO environments, the "hero move" of pushing past our physical limits often creates the exact failures we are trying to prevent. Real leadership means enforcing tactical patience and recognizing when a tired Soldier needs to be pulled off the flight line. After all, a down aircraft cannot save lives. ■





# BEYOND THE HUNT

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**Between fiscal year 2010 and to date in fiscal year 2026, the U.S. Army recorded 49 off-duty hunting-related mishaps that resulted in nine fatalities and over $58.5 million in injury costs. While hunting is a valued tradition for many service members, the data reveals that these mishaps, though infrequent, carry disproportionately severe consequences. With a Class A mishap rate of 20% and an 18% fatality rate, these incidents demand focused attention. Understanding the patterns and causes enables leaders and safety managers to develop targeted prevention strategies that respect Soldiers' recreational choices while promoting safe practices.**

## Scope and Severity

Over the 17-year study period, the Army averaged about three hunting mishaps per year, but this frequency masks their true impact. Ten mishaps were classified as Class A — the most severe category involving fatalities, permanent disabilities or costs exceeding $2.5 million. The 27 Class C incidents involved lost workdays and significant medical treatment, while the 12 Class D mishaps required restricted duty. The absence of Class B mishaps and the concentration in Class A and C categories indicates that when hunting incidents occur, they tend to be either catastrophic or moderately severe, with few minor outcomes.

All nine documented fatalities occurred during off-duty recreational activities, highlighting the challenge of extending safety culture beyond duty hours and installation boundaries. The 18% fatality rate significantly exceeds that of other recreational activities, underscoring the inherent dangers of hunting. Beyond fatalities, one Soldier sustained permanent total disability from a tree stand fall, resulting in paralysis and lifelong impact. The total injury cost of $58.5 million, averaging $1.2 million per mishap, reflects both the severity of injuries and the long-term medical and disability expenses associated with hunting incidents.

Lost duty time compounds the impact on unit readiness. The recorded mishaps generated 2,170 total lost duty days, including 121 days of hospitalization, 597 days quartered and 1,452 days of restricted duty. This averages to 44 lost duty days per mishap, representing significant degradation of unit strength and requiring training of replacement personnel. The human cost extends beyond statistics to affect families, units and the broader Army community.

## Mishap Categories and Hazard Profiles

Hunting mishaps span four primary categories, each presenting distinct hazard profiles and requiring tailored prevention strategies:

- Sports, Recreation and Physical Fitness (27 incidents): This is the largest category, accounting for 55% of all hunting mishaps. This category encompasses falls from elevated hunting stands, terrain-related injuries, environmental exposure incidents and physical exertion injuries. While representing the highest overall volume, this category has a moderate fatality rate of 11%, resulting in three of the nine total fatalities along with the single documented permanent total disability. However, the average injury cost of $774,000 per incident and an average of 2.35 days of hospitalization indicate serious, though often survivable, injuries.
- Weapons and Explosives (11 incidents): This was the deadliest category by proportion, presenting the highest sustained risk with a 36% fatality rate. Four of the nine total hunting fatalities occurred in this category, making it the most lethal. The average injury cost of $1.7 million per incident reflects the severe and often permanent nature of gunshot injuries. These mishaps include unintended impacts where hunters shot companions mistaken for game, accidental discharges during weapon handling and ricochets. The heavy concentration of Class A mishaps in this category — 36% compared to just 15% in sports and recreation — demonstrates the catastrophic potential of weapons-related failures.
- Motor Vehicle (2 incidents): Both recorded incidents resulted in Class A mishaps, with an average injury cost exceeding $9.2 million per incident and 15 days of hospitalization for survivors. One incident involved Soldiers ejected from a truck bed while traveling to a hunting location on unimproved terrain, resulting in one fatality and one serious injury costing $8.9 million. The second involved a vehicle rollover while traveling to hunt, costing $9.6 million. These incidents highlight the often-overlooked transportation risks associated with hunting, particularly when using private vehicles on unimproved roads or off-road terrain to access remote areas.
- Other Ground Mishaps (9 incidents): This category presented the lowest severity, with zero fatalities and minimal hospitalization averaging 0.44 days. These incidents typically involved knife cuts while field dressing game, injuries from handling trapped animals, slips and falls during hunting and miscellaneous ground incidents. The average injury cost of $12,500 per incident was the lowest of all categories. While requiring medical attention and

resulting in lost duty time, these incidents rarely threatened life or resulted in permanent disability.

**Critical Incident Patterns**

Examining specific incident mechanisms reveals actionable prevention opportunities:

- Tree Stand Falls: Falls from tree stands represent one of the most frequent and serious non-fatal hazard patterns. Multiple incidents involved falls from elevated hunting stands at heights ranging from 20 to 29 feet, resulting in severe injuries, including spinal fractures, paralysis, multiple bone fractures and internal organ damage. The most catastrophic tree stand incident occurred in fiscal 2026 when a Soldier fell 29 feet after both the support cable and safety harness failed. This resulted in a severed spinal cord and permanent paralysis with an injury cost of $1.2 million. Common causal factors included failure to use safety harnesses, disconnecting harnesses during transitions between the ground and stand, equipment failures such as straps or cables breaking, and structural failures when branches or stand components broke under weight. The severity of injuries correlates directly with fall height, with falls exceeding 20 feet consistently resulting in serious injuries requiring hospitalization and extended restricted duty.
- Unintended Impacts: Incidents where hunters shot companions or bystanders accounted for seven mishaps with three fatalities. These incidents share common factors: failure to positively identify targets before shooting, inadequate backstop awareness, shooting at movement or sound rather than clearly identified game and failure to wear hunter orange clothing. The consequences are typically catastrophic, as gunshot wounds to the torso or head rarely allow for survival, particularly in remote hunting locations far from trauma care. One Soldier was shot while driving by a hunter firing at a deer across the road, resulting in a $9.6 million fatality. Another was shot by a family member during a hunting trip, costing $8.7 million.
- Unintentional Discharges: Involving four mishaps with no fatalities, these incidents occurred during weapon-handling activities such as loading, unloading, holstering or transitioning between carry positions. While injury outcomes were less severe than unintended impact incidents, they represent preventable failures in basic weapons-handling discipline. One notable case involved a Soldier's dog jumping during raccoon hunting, causing the rifle to discharge and resulting in a nonfatal injury valued at $125,000. Another involved a shotgun discharging into a Soldier's feet while loading the weapon, costing $21,000.
- Drowning: Drowning represented a unique and particularly tragic hazard pattern. Four fatal drowning incidents occurred when hunters attempted to cross water obstacles to reach hunting areas



**"With human error accounting for 88% of all incidents, most hunting mishaps can be prevented through better decision-making and adherence to established safety procedures."**

or retrieve game, or during waterfowl hunting activities. One Soldier drowned attempting to swim across the Pecos River to reach a hunting campsite, costing $8.7 million. Another drowned while crossing a creek in Alaska during a hunting trip, also costing $8.7 million. The 100% fatality rate for drowning incidents reflects the remote locations, cold water temperatures, weight of hunting equipment and clothing that impedes swimming and lack of personal flotation devices. Drowning represented 44% of all hunting fatalities, making it the single leading cause of death despite representing a small percentage of total incidents.

## Causal Factors and Prevention Opportunities

Human error accounts for 88% of all hunting mishaps, representing the most significant prevention opportunity. This overwhelming predominance indicates that most hunting injuries are preventable through better decision-making, adherence to safety procedures and proper use of safety equipment. Specific human error patterns include failure to use safety equipment such as harnesses or flotation devices; improper weapons handling, including violations of fundamental firearms safety rules; target identification failures where hunters fired at movement or sound without positive identification; poor risk assessment, including attempting dangerous water crossings or hunting in extreme weather; and inadequate preparation such as failing to inspect equipment before use.

Mishaps classified as material failure accounted for only three incidents, though these included the catastrophic tree stand incident resulting in permanent paralysis. Equipment failures involved tree stand support cables or straps breaking, safety harness failures, and structural failures of branches or stand components. While representing a small percentage of mishaps, "material failures" are usually caused by human error, such as failure to inspect equipment, using equipment beyond its service life, or improper installation and maintenance, and are not actual failure of equipment.

Environmental factors were cited as the primary cause in only two mishaps, though environmental conditions contributed to many others. These included incidents where weather conditions such as ice or wet surfaces, or terrain features such as unstable ground or hidden obstacles, created hazards that resulted in injuries. Environmental factors are often blamed for inadequate risk assessments. The drowning incidents, while classified under various primary causes, all involved environmental factors, including water hazards, cold temperatures and currents that exceeded victims' ability to cope.

## Conclusion

This analysis reveals clear and preventable patterns. With human error accounting for 88% of all incidents, most hunting mishaps can be prevented through better decision-making and adherence to established safety procedures. The concentration of risk in specific areas — tree stand falls, weapons handling, water crossings and vehicle operations — provides leaders and safety managers with clear targets for prevention efforts. By using this data to provide education and resources, leaders can develop targeted interventions that address the most significant risks and prevent future tragedies while respecting Soldiers' choices to participate in this valued recreational activity. ■



# THE LEFT-TURN THREAT

**A recent near-miss traffic incident between a motorcycle and a passenger vehicle served as a stark reminder of the split-second margins that dictate survival for riders on the road. The incident occurred about 1:30 p.m. at the intersection of South County Highway 395 and East Royal Fern Way, a popular corridor cutting through the Point Washington State Forest area of Santa Rosa Beach, Florida. Under clear skies, dry road conditions and moderate spring traffic, what began as a routine ride nearly turned catastrophic.**

According to the 38-year-old rider, he was cruising northbound in the right lane of Highway 395 at about 45 mph, matching the posted speed limit. As he approached the intersection, a civilian motorist in a westbound four-door sedan failed to yield the right of way and initiated a left turn across the oncoming lanes. Realizing the sedan had cut off his path, the rider only had a fraction of a second to react. Using his defensive riding techniques, the rider executed a rapid, controlled deceleration while counter-steering into a sharp swerve toward the left edge of his lane. The maneuver allowed him to narrowly clear the sedan's front bumper, and both motorists escaped without injury or property damage.

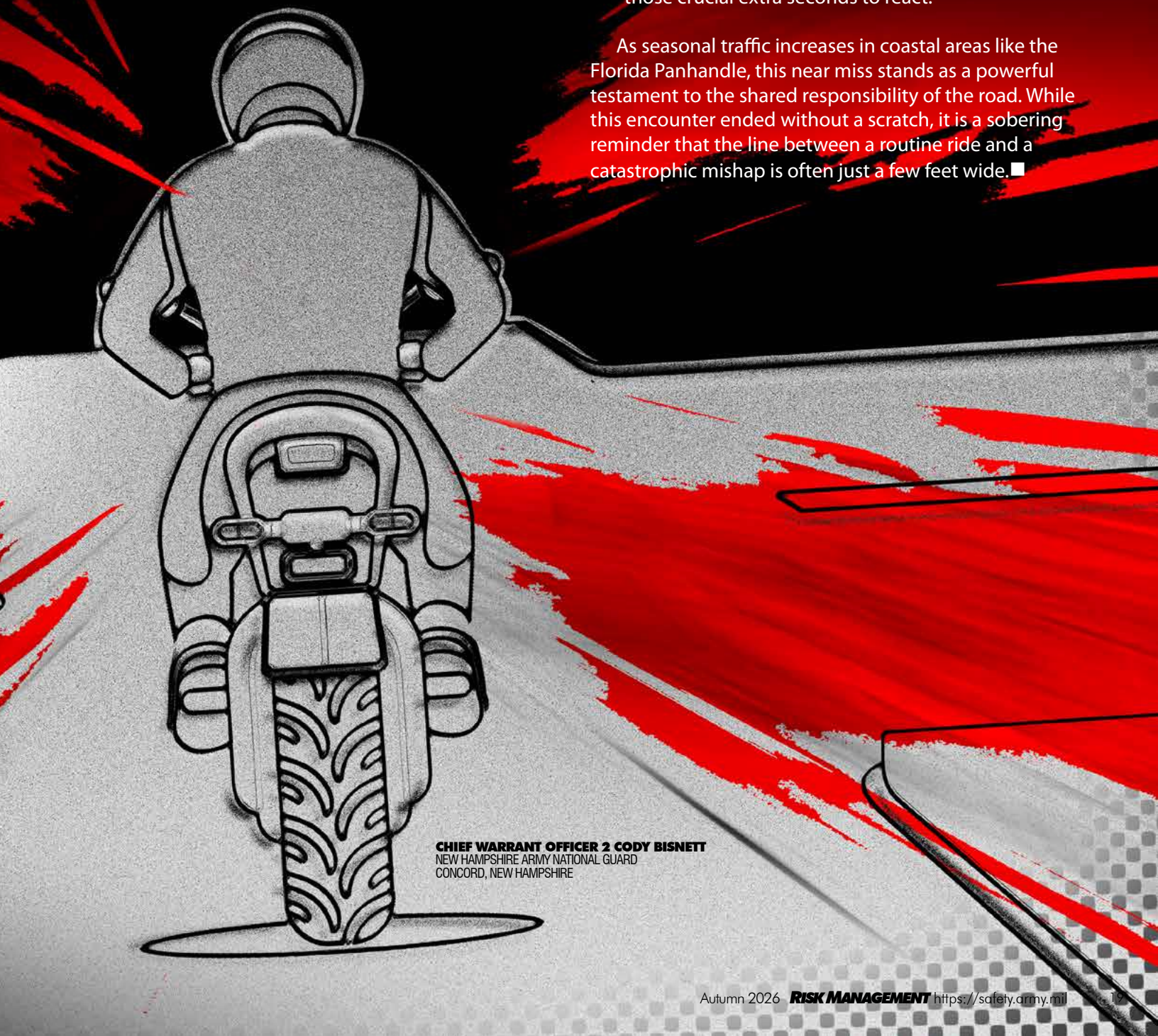
Motorcycle safety experts say this incident is a textbook example of one of the most hazardous scenarios riders face on public roads. According to federal highway safety data, left-turning vehicles crossing a rider's path account for more than one-third of all multi-

vehicle motorcycle crashes. The primary culprit is often driver inattention or a cognitive phenomenon known as the "time compression effect." Because motorcycles have a much smaller visual profile than passenger vehicles, the human brain struggles to accurately judge their closing speed and distance. Drivers looking in the direction of an oncoming motorcycle frequently perceive it as traveling slower or being farther away than it actually is, leading to fatal miscalculations.

In this instance, the rider's active situational awareness and prompt braking proficiency proved to be the difference between a close call and a fatal collision. Traffic safety analysts note that a rider's lane positioning, continuous scanning and readiness to swerve are often their only lines of defense when a motorist's attention lapses. To combat these recurring hazards, motorists and riders are urged to adopt proactive habits.

- For drivers, public awareness campaigns like "Look Twice for Motorcycles" emphasize checking blind spots twice before committing to a turn. Because drivers naturally scan for larger visual targets like cars or trucks, they must train themselves to actively look for smaller profiles, including motorcycles, bicycles and pedestrians.
- For motorcyclists, this incident underscores the lifesaving value of advanced rider training, high-visibility clothing and daytime running lights. Wearing vibrant gear helps break up a rider's profile against natural backdrops, such as the dense foliage of the Point Washington State Forest, giving drivers those crucial extra seconds to react.

As seasonal traffic increases in coastal areas like the Florida Panhandle, this near miss stands as a powerful testament to the shared responsibility of the road. While this encounter ended without a scratch, it is a sobering reminder that the line between a routine ride and a catastrophic mishap is often just a few feet wide.■



**CHIEF WARRANT OFFICER 2 CODY BISNETT**
NEW HAMPSHIRE ARMY NATIONAL GUARD
CONCORD, NEW HAMPSHIRE

# EXPERIENCE ISN'T ENOUGH

**SGT. 1ST CLASS JACOB THURBER**
87TH TROOP COMMAND
ARKANSAS ARMY NATIONAL GUARD
NORTH LITTLE ROCK, ARKANSAS

**According to the National Safety Council's 2024 statistics, accidental firearm deaths accounted for just 1% of all gun-related fatalities. While that percentage might not seem significant, it is devastating when you realize that every single one of them was preventable. The dangerous truth is that an accidental discharge can happen to anyone, even the most experienced individuals. My brother and I are proof of that. We grew up as avid hunters and are no strangers to guns. But experience can sometimes breed a dangerous level of complacency.**

The reality check came shortly after I returned home from a deployment to Afghanistan. My brother came over to hang out since we hadn't seen each other in months. We were relaxing in my living room. I was laying on the couch trying to rest when he decided to take out his new Springfield XD .45 pistol to clean it. I couldn't sleep, so I just lay there facing the opposite way, listening to him fiddling with the weapon and wiping down the parts. About 30 minutes passed when the distinct sound of a magazine being seated broke the quiet. A second later, I heard him pull back the slide and chamber a round.

My military training immediately kicked in. The slide should have locked to the rear if the magazine was empty, so the sound instantly caught my attention. I started to roll over to see if he was finishing up and putting the gun away. As I looked over, I watched him bring the pistol up and get a sight picture right on the center of my television. Before I could even ask what he was doing, a deafening shot rang out in my living room. Honestly, I think I was less surprised that he had just put a .45-caliber hollow point through my TV than he was.

My brother was in absolute shock. He immediately apologized, stammering that he wasn't sure what had just happened. After my initial wave of surprise and anger subsided, I couldn't help but chuckle. I looked at him and said, "You loaded a gun and shot my TV." We argued for a bit until he finally accepted the hard truth: he simply wasn't paying attention. As I mentioned earlier, we had been around firearms our entire lives, and nothing like this ever happened. In fact, I always considered him overly cautious with weapons. After talking it through, we realized he had become a little too comfortable and nonchalant. It was a new pistol, and he was excited to see if he could break it down and reassemble it, letting his basic safety fundamentals slip in the process.

I often think about that day when I am cleaning my own weapons, and I have certainly never let him forget it. That mistake only cost him an immediate trip to Best Buy to replace the television. But what could it have cost? What if someone had been walking by when he pulled the trigger? What if he had jokingly pointed the weapon at me? Privately owned weapon safety must be constantly reinforced, regardless of how much experience a person has.

As Soldiers, we receive extensive, repetitive training on weapons handling, which is exactly why I recognized the sound of a loaded chamber before he even realized what he had done. We have a responsibility to keep an eye out for our often less-trained civilian counterparts. An unintentional discharge happens in the blink of an eye. If my brother had taken just one extra second to realize he was inserting a loaded magazine, he would have saved himself some money and avoided a mistake that could have cost him everything. ■

**"The dangerous truth is that an accidental discharge can happen to anyone, even the most experienced individuals."**



# The Double-Edged

**Armed forces across the globe are strapping explosives to remote-controlled drones. These small unmanned aerial systems (sUAS) are game changers, allowing units to gather crucial information and deliver deadly strikes without putting Soldiers directly in harm's way. But this incredible tactical advantage brings plenty of new dangers to the battlefield. While these drones are undeniably helpful for commanders and Soldiers alike, understanding the risks they introduce is the only way we can figure out the best methods to keep our formations safe.**

## The Dangers of the Drone Fight

Using armed drones is a classic double-edged sword. On one hand, they give our troops a major advantage. On the other, the risks are serious, including friendly fire mishaps, enemies turning our own technology against us and drone operators inadvertently making themselves easy targets.

1. Mishaps and friendly fire – Dropping a bomb from a small, flying drone is surprisingly difficult. A simple mistake, a sudden drop in communication or even a strong gust of wind can send an explosive way off course. That means the risk of accidentally injuring our own troops or innocent bystanders is always looming.
2. The enemy can fight back – Every drone sends signals back to its operator, and to an enemy. That signal is a homing beacon. Once they trace it, they can fire rockets or mortars right at the Soldier flying the drone or even send their own drones to drop munitions. Enemies can also jam the signal to crash the drone, or hack in to hijack it. And since these systems are cheap, they can easily buy their own and throw the exact same threats right back at our Soldiers.
3. Equipment frustrations – The gear we currently rely on to shoot down enemy drones is often large and, frankly, ineffective. When Soldiers don't trust their equipment to do the job, it kills morale and puts them at unnecessary risk.



## How We Can Reduce the Risks

We can manage these threats and protect our Soldiers by focusing on three straightforward areas:

1. Drone and anti-drone training for everyone – As we've seen in current conflicts, defending against drones is everybody's business. The old idea of a safe rear area and a clear front line just won't hold up in the next fight. We need multiple drone operators right down at the squad level, not just one or two in a platoon and a handful in the company headquarters platoon. Furthermore, drone defense can't just be left to a few Stinger missiles placed

# Sword in the Sky:

## Navigating the New Era of Armed Drones

around key command nodes by the battalion. We need layered systems — mixing new tech with simpler, cost-effective approaches. Think about it: can everyone in your platoon successfully shoot a clay pigeon?

2. Practice with dummy munitions – We should swap in blank or dummy munitions during maneuver training. By using sUAS to drop dummy rounds during simulated training exercises, Soldiers get the chance to build familiarity and effectiveness. It might not be as flashy as seeing a real explosion, but removing the need for a dedicated live-fire impact area greatly reduces the land and safety constraints required for practice.
3. Simplify tactics and empower decision-making – Clear rules and simple tactics make all the difference. Operators should live by "launch-and-run" tactics so they never stay in one spot too long. Meanwhile, Soldiers on the ground need to use hills, trees and buildings to hide from overhead eyes, adding local foliage and gear like poncho liners to mask their thermal signatures. Getting cheaper, lighter anti-drone gear down to lower echelons will drastically increase the size of a unit's protective air-defense bubble. Ultimately, armed drones need to be treated as expendable items, and commanders must plan for airspace coordination right at the start of their troop-leading procedures, not as an afterthought.

**Final Thoughts**

Armed drones are here, and they are only going to get more sophisticated. While the dangers are real, we can manage the risks and become a more effective force. By training more Soldiers, practicing with dummy munitions to mirror how we actually fight, and keeping our tactics simple, we can protect our Soldiers and safely use these new tools to win. The biggest takeaway is that technology alone doesn't ensure victory. If we want to reap the benefits of armed drones without paying a heavy price, we have to weave both flying them and fighting them into the daily habits of every Soldier. ■

**"By training more Soldiers, practicing with dummy munitions to mirror how we actually fight, and keeping our tactics simple, we can protect our Soldiers and safely use these new tools to win."**



**CAPT. JUSTIN BOGGS**
GRAFENWOEHR TRAINING AREA RANGE OPERATIONS, TRAINING SUPPORT ACTIVITY EUROPE,
7TH ARMY TRAINING COMMAND
GRAFENWOEHR, GERMANY

**The U.S. military continuously adapts to understand and prepare for various operational environments. Yet hazards like slips, trips and falls remain a constant threat. Training Soldiers to operate in a field environment is both physically and mentally demanding. It is important to understand that no matter how many controls are implemented and enforced, there is always a residual risk of injury due to falls. According to the Defense Centers for Public Health–Aberdeen (DCPH-A) annual injury surveillance report, just over 20 percent of mechanism-related injuries in 2022 were attributed to slips, trips and falls. This occupational hazard can affect anyone in garrison. However, during a training exercise — where mission variables affect everyone's decision-making process — the probability of tripping or falling is an ever-present risk.**

While stationed at Joint Base Lewis-McChord, Washington, I was still one of the newer members of a chemical unit when they conducted a field training exercise at Camp Rilea – a National Guard training area in Oregon. The goal was to enhance our ability to provide command and control functions while operating in a different location. The staff had attended the National Training Center (NTC) at Fort Irwin, California, less than a year prior, and they were eager to practice the improved systems and processes they recently revised. The leaders acknowledged there were multiple near misses and mishaps that could have been avoided, but the experience at NTC allowed them to think more proactively in their approach to the upcoming training event in the spring season.

At the exercise site, the unit stood up the administration and logistics operations center (ALOC) within the first 24 hours. Although our Soldiers were accustomed to the muddy terrain and rain from Washington, I was still surprised how quickly they established their position. They dropped their containers, draped the camouflage netting and established workstations in the back of a Light-Medium Tactical Vehicle (LMTV). Because the stairs to the LMTV door were steep and slightly slippery, the railing was installed, even though it forced one door to remain closed. All Soldiers involved wore their gloves, eye protection and combat helmets until the section was fully operational. Leaders and subordinates alike enforced safety precautions and controls without hesitation, until it was time to jump.

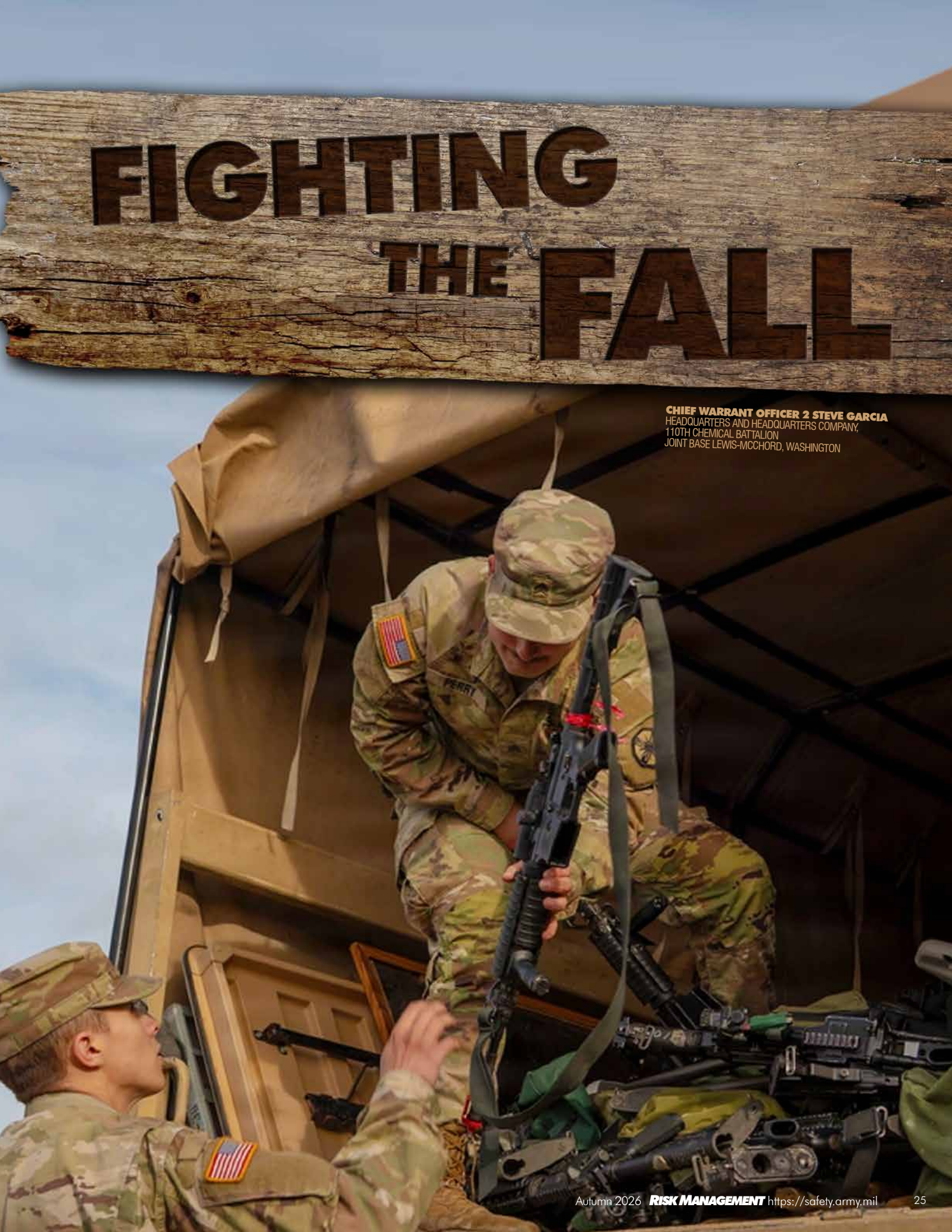
When the staff received orders to relocate the ALOC, personal protective equipment (PPE) suddenly became an afterthought. Even as the rain picked up, none of the Soldiers donned their wet-weather gear. Rushing to prepare for the move, they quickly packed their containers and generators, and leaders removed the stair railing to allow boxes to be loaded more easily into the LMTV. The Soldiers broke into two-man teams to lift the boxes inside, while another team received and organized them. Upon completion, operators staged the vehicles and rolled out as instructed.

The teardown happened smoothly with no reported injuries or damage, which created a false sense of security for the next setup phase. While unloading at the new site, a noncommissioned officer (NCO) placed a bag of camouflage nets dangerously close to the back edge of the LMTV. Noticing a strap that needed tightening, he stepped on the bag for leverage. The bag suddenly slipped over the edge, sending the NCO tumbling out right behind it. Soldiers tried to grab him, but fortunately, his fall was broken by the pile of camouflage nets below. This close call compelled the NCO to walk the perimeter and ensure others weren't making similar mistakes.

Falling from a vehicle might sound funny, but witnessing it firsthand offers a starkly different perspective. Regardless of the administrative controls in place, variables like time, fatigue and complacency directly affect our decisions to wear PPE and follow standard operating procedures. Acknowledging this near miss, reporting the lesson learned and staying vigilant ultimately allowed my unit to return from the training safely. ■

**"Regardless of the administrative controls in place, variables like time, fatigue and complacency directly affect our decisions to wear PPE and follow standard operating procedures."**

# FIGHTING THE FALL



**CHIEF WARRANT OFFICER 2 STEVE GARCIA**
HEADQUARTERS AND HEADQUARTERS COMPANY,
110TH CHEMICAL BATTALION
JOINT BASE LEWIS-MCCHORD, WASHINGTON

# THIRD-QUARTER FY26 MISHAP BRIEFS

## ON-DUTY FATAL MISHAPS

**Industrial/Occupational**

A 23-year-old Sergeant assigned to 2nd Brigade Combat Team, 3rd Infantry Division, Fort Stewart, Georgia, died in an Industrial/Occupational mishap 10 April 2026 on the installation at 1530 local. The Soldier was under a tactical vehicle that suddenly lowered, crushing him. Nearby medics rendered first aid and emergency services were called. The Soldier was transported to Winn Army Community Hospital via ambulance, where he died.

A Department of the Army Civilian assigned to Naval Support Activity Mid-South, Millington, Tennessee, died in an Industrial/Occupational mishap 11 May 2026 at 0820 local. The employee was operating a forklift outside with a pallet of recyclables when it tipped over off the sidewalk, pinning him underneath. While there were no direct witnesses to the mishap, a Navy service member driving by noticed the overturned forklift, stopped to help and called 911. Two additional personnel arrived and also attempted to assist. Emergency medical services responded, removed the employee from under the forklift and transported him to a local hospital, where he was pronounced dead.

**Aviation**

A Soldier died in an aviation mishap 31 May 2026 in Erbil, Iraq, at 1920 local. The mishap occurred during rescue hoist training operations involving an HH-60M aircraft.

**GMV**

A Specialist assigned to Fort Stewart, Georgia, died in a Government Motor Vehicle (GMV) mishap 10 June 2026 at the National Training Center, Fort Irwin, California, at 0430 local. During a training rotation, the Soldier and his platoon were emplacing an obstacle in preparation for an upcoming force-on-force engagement when a Bradley Fighting Vehicle entered the area and struck him. He was pronounced dead at the scene.

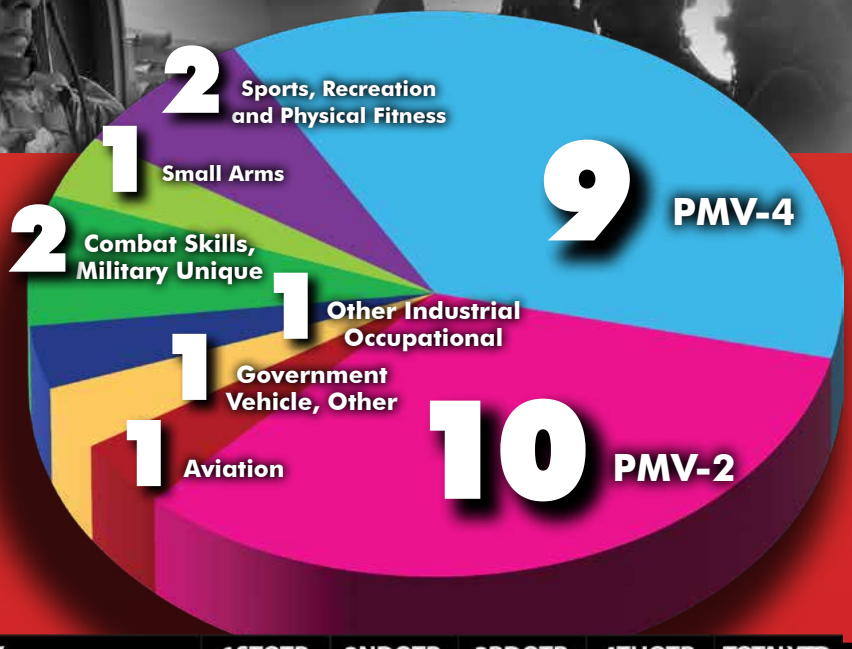
**Combat Skills/Military Unique**

A 21-year-old Private Second Class assigned to 2nd Brigade Combat Team, 101st Airborne Division, Fort Campbell, Kentucky, died in a combat skills/military unique mishap 15 April 2026 on the installation at 1500 local.





# THIRD-QUARTER ARMY MILITARY MISHAP FATALITIES




**TOTAL: 58**

as of 1 Oct 26

| CATEGORY | 1STQTR | 2NDQTR | 3RDQTR | 4THQTR | TOTALYTD |
|---|---|---|---|---|---|
| Aviation | 0 | 0 | 1 | | 1 |
| GMV | 1 | 0 | 0 | | 1 |
| Government Vehicle, Other | 2 | 1 | 1 | | 4 |
| Combat Skills/Military Unique | 0 | 0 | 2 | | 2 |
| Other Industrial Occupational | 0 | 0 | 1 | | 1 |
| Sport, Recreation and Physical Fitness | 1 | 1 | 2 | | 4 |
| PMV-2 | 6 | 2 | 10 | | 18 |
| PMV-4 | 6 | 10 | 9 | | 25 |
| PMV-Pedestrian /Non-Motorist | 1 | 0 | 0 | | 1 |
| Small Arms | 0 | 0 | 1 | | 1 |
| Total | 17 | 14 | 27 | | 58 |

While in the tactical operations center tent performing mission requirements for the Army Team Leader Academy, the Soldier was struck in the head and neck by a falling branch, resulting in fatal injuries.

A 23-year-old Specialist assigned to Camp Mackall, North Carolina, died following a Combat Skills/ Military Unique mishap 11 June 2026 at 1654 local. The Soldier was found unresponsive while participating in a land navigation exercise. He was evaluated by cadre and a special forces medical sergeant before being transported to the troop medical center. He was subsequently transported to a local hospital for advanced treatment for a heat illness, where he remained unresponsive and died 20 June 2026.

## OFF-DUTY FATAL MISHAPS

**PMV-4**

A Specialist assigned to Smith Barracks, Germany, died in an automobile mishap 25 April 2026 in Idar-Oberstein, Germany, at 0100 local. The Soldier's vehicle struck a guardrail before entering oncoming traffic, where it collided with a vehicle traveling in the opposite direction.

A Sergeant assigned to East Camp, Grafenwoehr, Germany, died in an automobile mishap 2 May 2026 in Italy at 0435 local. Two Soldiers were involved in a vehicle mishap with a semi-truck. One of the Soldiers sustained fatal injuries.

A 40-year-old Active Guard Reserve Sergeant First Class assigned to the National Guard Bureau died in an automobile mishap 1 May 2026 in Lincoln County, Mississippi, at 0845 local. The Soldier's vehicle was struck by another vehicle. The other driver, a Soldier on orders for drill weekend, sustained minor injuries.

A 34-year-old Sergeant assigned to Fort Hood, Texas, died in an

# THIRD-QUARTER FY26 MISHAP BRIEFS

automobile mishap 9 May 2026 in Travis County, Texas, at 0300 local. The Soldier's vehicle collided with an unknown object. Local police and emergency medical services personnel pronounced him dead at the scene. The Soldier's passenger was transported to a local hospital and later released.

- A 21-year-old Specialist, a 20-year-old Private First Class, and a 19-year-old Private First Class assigned to Fort Bragg, North Carolina, died in an automobile mishap 13 June 2026 in Apex, North Carolina, at 0020 local. According to law enforcement, four Soldiers were riding in a single-passenger vehicle that left the roadway at approximately 100 mph and rolled multiple times. The North Carolina State Highway Patrol responded to the scene, where three Soldiers were pronounced dead. The fourth Soldier was transported to a local hospital for surgery. Two of the three Soldiers who died were reportedly not wearing seat belts.

- A 25-year-old Sergeant assigned to U.S. Army Reserve Center, Tustin, California, died in an automobile mishap 16 June 2026 in Fontana, California, at 1653 local. The Soldier was on active-duty orders when his vehicle collided with a tractor-trailer. The California Highway Patrol and emergency medical services responded to the scene, where the Soldier was pronounced dead.

- A 19-year-old Private First Class





assigned to Fort Bliss, Texas, died in an automobile mishap 27 June 2026 near Sherman, Texas, at 0046 local. The Soldier was traveling eastbound on the highway when an oncoming truck towing a flatbed trailer attempted a U-turn. The truck failed to yield the right-of-way, crossing into the eastbound lanes and directly into the Soldier's path. The Soldier's vehicle struck the rear of the trailer and wedged underneath it, resulting in fatal injuries.

**PMV-2**

- A 19-year-old Private First Class assigned to Joint Base Lewis-McChord, Washington, died in a motorcycle mishap 18 April 2026 in Olympia, Washington, at 1410 local. The Soldier was negotiating a curve when he crossed into the northbound lane, collided with another vehicle and then struck an embankment. Local police and emergency medical services personnel responded to the scene, where the Soldier was pronounced dead.

- A 43-year-old Master Sergeant assigned to Fort Carson, Colorado, died in a motorcycle mishap 17 May 2026 in Colorado Springs at 0425 local. The Soldier's motorcycle collided with a passenger car. The Colorado Springs Police Department and emergency medical services personnel responded to the scene, where the Soldier was pronounced dead.

- A 22-year-old Specialist assigned to Joint Base Elmendorf-Richardson, Alaska, died in a motorcycle mishap 25 May 2026 in Turnagain Arm, Alaska, at 1500 local. The Soldier was operating his motorcycle when he collided with a passenger vehicle as it attempted to turn onto the highway. The Anchorage Police Department responded to the scene, where the Soldier was pronounced dead.

- A 24-year-old Specialist assigned to Fort Campbell, Kentucky, died in a motorcycle mishap 28 May 2026 in Clarksville, Tennessee, at 1900 local. The Soldier collided with an SUV that turned left across his lane. Police and emergency medical services personnel responded to the scene, where he was pronounced dead. A second rider received minor injuries and was transported to a local hospital.

- A 28-year-old Specialist assigned to Fort Carson, Colorado, died in a motorcycle mishap 30 May 2026 in Colorado Springs, Colorado, at 2352 local. The Soldier lost control after passing another vehicle and was ejected from his motorcycle. He then slid into the oncoming traffic lane, where he was struck by an oncoming vehicle. The El Paso County Sheriff's Department responded to the scene, where the Soldier was pronounced dead.

- A 24-year-old Sergeant assigned to Fort Carson, Colorado, died in a motorcycle mishap 6 June 2026 in Colorado Springs, Colorado, at 0100 local. The Soldier was riding westbound in a residential area when he collided head-on with another vehicle. He was pronounced dead at the scene.

- A 23-year-old Sergeant assigned to Camp Ederle, Vicenza, Italy, died in a motorcycle mishap 10 June 2026 in Gila Bend, Arizona, at 0600 local. The Soldier was operating his motorcycle while on leave when he was struck by a passenger car. The Arizona Department of Public Safety responded to the scene and transported him to a local hospital, where he died.

- A 20-year-old Private First Class assigned to Fort Hood, Texas, died in a motorcycle mishap 28 June 2026 in Limestone County, Texas, at 1930 local. The Soldier was operating his motorcycle when he was struck by a vehicle at an intersection. The Texas Department of Public Safety and emergency medical services responded to the scene, where the Soldier was pronounced dead.

**Sports, Recreation and Physical Training**

- A 27-year-old First Lieutenant and a 19-year-old Specialist assigned to Urlas Kaserne, U.S. Army Garrison Ansbach, Germany, died in an off-duty Sports, Recreation and Physical Training mishap 2 May 2026 in Morocco at 2015 local. The Soldiers were with a group that went to observe the ocean at sunset after duty hours. One Soldier accidentally fell in, and two others entered the water to rescue her. The first Soldier and one of the Soldiers attempting to rescue her were swept away. Their remains were found following a week of search-and-rescue operations.

**Weapons and Explosives**

- A 22-year-old Sergeant assigned to Fort Riley, Kansas, died in an off-duty Weapons and Explosives mishap 9 May 2026 at 1900 local. The Soldier was handling a privately owned pistol at a co-worker's residence when it was unintentionally discharged, striking him in the head. Another Soldier called 911, and local police and emergency medical services personnel responded to the scene, where the Soldier was pronounced dead.

# READY FOR A FALL RIDE?

***Fall rides often feature beautiful, scenic views, but they also pose some unique hazards.***



### Adaptable Riding Gear
The weather in fall is transitional and may change abruptly. Adaptable riding gear is a great idea.

### Beware of Poor Visibility
The sun is typically at a lower angle in the sky. Shadows may become longer, darker and occur earlier in the day than during mid-summer. Wearing lightly tinted shades or a helmet with a retractable sunshade can help improve vision into those dark shadows.

### Watch for More Active Wildlife
Wild animals tend to become more active in autumn due to mating, migration or foraging. Throttle down, cover your brake an be prepared to take evasive action or hard stopping.

### Beware of Traction Surprises
On lightly traveled roads, overnight frost can linger on road surfaces into the latter part of the morning. Frost can be as slick as ice, so be alert.to road conditions in the shadows can help avoid nasty surprises.

***Perhaps the Best Tip of All:***

***RIDE SAFE, SLOW DOWN AND ENJOY THE VIEWS!***



# AUTUMN & WINTER

**BE AWARE PREPARE TAKE CARE**

U.S. ARMY

https://safety.army.mil

# WHAT IS ARMY SAFETY*NET*?

**Safety*Net* is a knowledge-based online safety and occupational health (SOH) platform that encourages professional dialogue and exchange of loss-prevention information.**

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# ASMIS 2.0 IS HERE, AND YOU'LL LOVE IT!

# ASMIS 2.0

## Army Safety Management Information System



**HERE'S WHY:**
**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.
- 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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