ARMY GROUND RISK-MANAGEMENT PUBLICATION

COUNTERMEASURE

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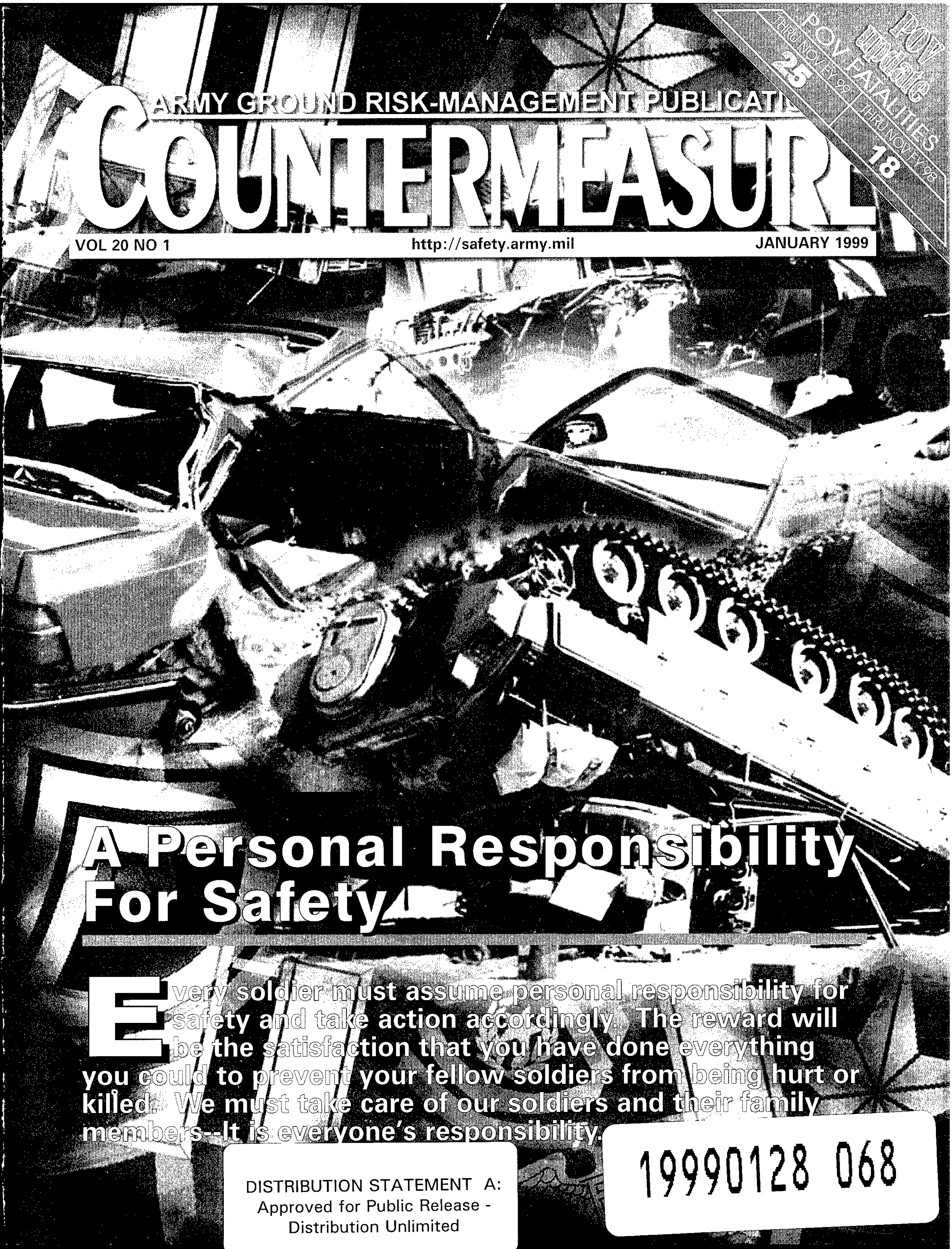
POV Update
POV FATALITIES
25 THRU NOV FY 99
18 THRU NOV FY 98



A Personal Responsibility For Safety

Every soldier must assume personal responsibility for safety and take action accordingly. The reward will be the satisfaction that you have done everything you could to prevent your fellow soldiers from being hurt or killed. We must take care of our soldiers and their family members--It is everyone's responsibility.

ARMY GROUND RISK-MANAGEMENT PUBLICATION
COUNTERMEASURE

The Official Safety Magazine for Army Ground Risk-Management

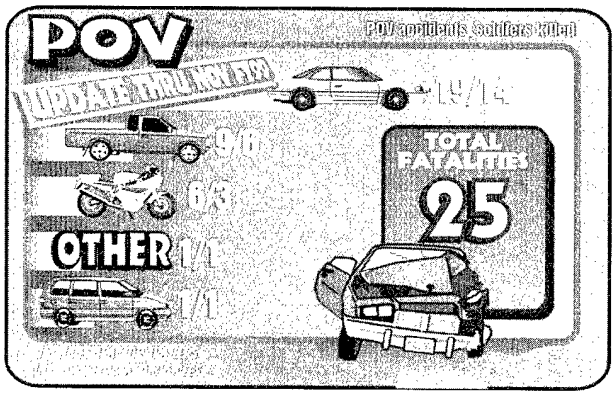
BG Charles M. Burke

COL John S. Warren

LTC Peter Simmons

Paula Allman

Mike Wilkins



U.S. ARMY SAFETY CENTER

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Charles M. Burke
Brigadier General, U.S. Army
Commanding Officer

From the Editor

Happy New Year to all. Now is the time to make a New Year's resolution that's important to everyone. Let's make an effort to have a strong safety program this year. This should be an easy task compared to the other ones about eating less, exercising more, or quitting smoking that we try each year! And it can mean so much more to our soldiers and loved ones.

There are no special secrets to achieving a good safety program. The most important commitment that each one of us can focus on is to look after one another at all times. Many accidents and injuries could be prevented if each member of the chain of command--from the team leader right on up--took his safety responsibilities more seriously.

Through a combination of three key factors--proactive leadership, accountability, and risk management--we can stop killing our soldiers and destroying national resources.

Proactive leadership saves soldiers. We need to continue to choose the right leaders who will invest the required time, energy, and personal leadership in training and mentoring our individual soldiers and ensure that every soldier sets and maintains high standards, both on and off duty.

Accountability. Each soldier must take on a personal responsibility for the safety of himself and constantly stress risk management to others. Supervisors play a vital role in risk management and need to really get to know their people, understand their working conditions, their part in the overall mission, and stress the safety aspects of day-to-day actions at all times.

Risk management. We need to be constantly alert to unsafe practices, and stop them when we see them. We should stop and explain to the soldier, civilian, or contractor the dangers involved and stress the safe way to perform the act. Our soldiers need to understand risk management. What better way to train than to lead by example.

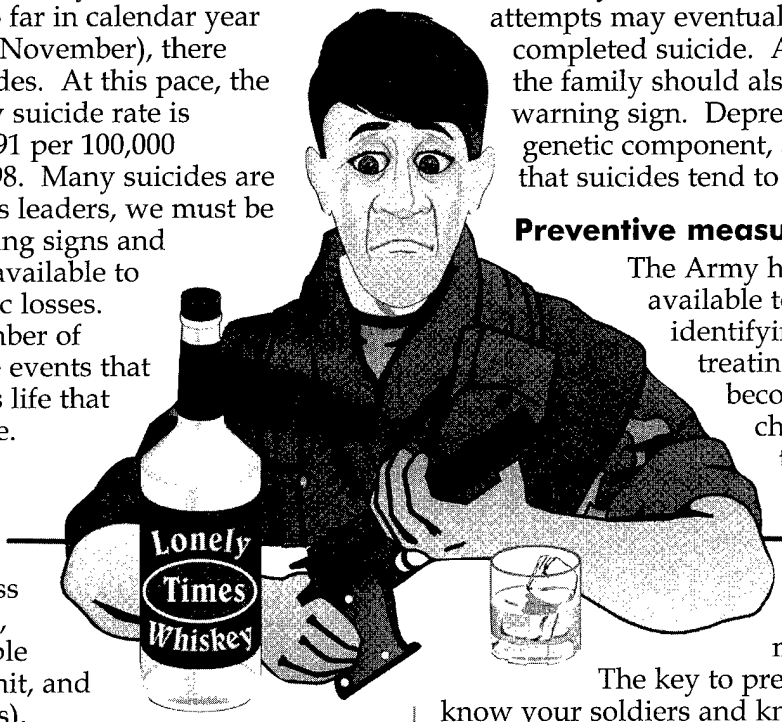
We can achieve a good safety program. It is everyone's responsibility. With everyone's personal commitment to safety--we can save precious lives. Have a safe 1999!

SAFETY FIRST!

Paula Allman

Suicide Awareness

The key to suicide prevention is positive leadership, careful listening, and deep concern for soldiers. As leaders, we have a duty to care deeply and sincerely for our subordinates and their families, and we must assure that assistance is provided when needed. The Army loses too many soldiers each year to suicide. So far in calendar year 1998 (through 24 November), there have been 57 suicides. At this pace, the Army's active duty suicide rate is projected to be 12.91 per 100,000 soldiers for CY 1998. Many suicides are preventable, and as leaders, we must be aware of the warning signs and corrective actions available to prevent these tragic losses.



There are a number of powerful, negative events that go on in a soldier's life that may lead to suicide. Those problems include: damaged relationships, depression, loneliness, job stress (change of mission, deployments, people rotating out of a unit, and working conditions), substance abuse (predominantly alcohol), civilian or military legal problems, and financial problems. When several of these occur in a soldier's life at one time, the stress can seem overwhelming.

Suicide warning signs

In many cases, there are warning signs present that indicate someone's potential to take their own life. Not all suicidal people show these signs, and not all people who display one or more are suicidal. These signs include:

Talking about suicide. Over half of the suicide cases studied showed that the victim told someone of the possibility of suicide. This can include a friend, spouse, co-worker, or a social service agency. If someone talks about suicide, take it seriously! Never assume they won't act on their thoughts.

Statements of hopelessness, helplessness, or worthlessness. Many victims that have these feelings suffer from depression.

Loss of interest in things one cares about. Sudden changes in interests or personality may indicate an impending suicide. The potential victim may also start giving away prized or valuable possessions, and may make arrangements to set their affairs in order.

A history of suicide attempts. A pattern of attempts may eventually end up in a completed suicide. A history of suicides in the family should also be considered a warning sign. Depression may have a genetic component, and statistics show that suicides tend to run in families.

Preventive measures

The Army has several resources available to assist leaders in identifying at-risk soldiers and treating them before they become victims. Unit chaplains are trained in this area and can provide valuable advice, counseling, and spiritual guidance to soldiers and family members.

The key to preventing suicides is to know your soldiers and know the warning signs of suicide. Listen to them when they talk about problems, and know if their personal lives include any of the risk elements described above. Take any threats seriously, and follow up on conversations or referrals to treatment. Let your soldiers know that depression is an illness, not a weakness, and that medical treatment can help. Encourage soldiers to let the chain of command know immediately if another soldier displays the warning signs, and emphasize that they're doing a huge favor that may save their buddy's life.

Don't keep it a secret. A soldier's buddy remains the most effective first-line of defense for detecting and preventing a suicide from occurring. ♦

Your concern and involvement can help save lives!

—Written by MAJ Monroe B. Harden, USASC Ground Systems Division, with LTC Mark Roupas of the Office of the Deputy Chief of Staff of Personnel contributing. Information can be found at http://www.odcsper.army.mil/info/hr/hr_pr

Accident Review

Curiosity Killed The... Airman

Curiosity. It can make the world an exciting and interesting adventure, or it can end that adventure.

Explosive devices are used around all military operations and many civilian construction projects. Too often, when curiosity meets an explosive device, death or injury results.

What happened.

The unit deployed to a testing range to collect air samples as part of a larger test. Their mission was to set up several mobile sample collection sites. Once set up, each two-person team would then change sample collectors and filters according to a time schedule, and would ensure that their equipment operated properly throughout the collection period.

Between filter and sample changes, there wasn't much for the team to do. Some participants brought correspondence course materials to read; others brought paperback novels or magazines. One team, however, decided to explore the local area during their down time.

The team set up near a main road. A large white trailer and two dummy bomb casings on trailers were in the field just east of their position. To their south, several hundred meters away, was a large fenced-in area. After changing their samples, the team members decided to walk around the site. The NCOIC walked across the road to examine the trailer and bomb casings, while his assistant walked south. About 150 meters from the collection site, the assistant saw a cylindrical yellow object on the ground. He picked it up to examine it, and then tossed it back to the ground. The object, an unexploded cluster bomb submunition, detonated as it hit the ground, killing him.

Why it happened.

There were two primary causes of this accident. First, the victim's chain of command did not train him on the hazards of unexploded ordnance (UXO). He had graduated from initial entry training a few months prior to this mission. He was also a last minute addition to the mission and missed most of the pre-deployment training. The make-up training that he received did not include anything about the hazards of UXO and the proper actions to take if UXO was discovered.

Also, the organization sponsoring the test did not require the participants to receive any training on UXO hazards. They did require them to receive training on the weather, animal, and equipment hazards peculiar to the test site. This particular installation had been frequently used in the past to conduct testing of explosives and munitions, and the post's Explosive Ordnance Disposal (EOD) team had a thorough briefing on UXO hazards available to anyone who requested it. But in this case, the sponsoring

DON'T TOUCH! This is an actual BLU-97 found in the vicinity of the accident scene.

agency did not request the class.

Corrective actions.

Leaders, you are responsible for your troops! Be sure to include the risks associated with UXO when conducting your risk assessments. If your training or testing site has been used for live munitions or demolitions firing in the past, consider the possibility of UXO in the area. If you are operating near a known impact area, expect UXO in the area. If an area has been used before, or has received a surface sweep for UXO, do not automatically assume it is completely free of dangerous objects. Erosion or shifting sands can uncover previously buried items, or someone could throw an item acquired elsewhere into your area.

Control measures available include training and site reconnaissance. FM 21-16 (UXO Procedures) and the Soldiers Manual for Common Tasks (STP-21-1-SMCT) contain procedures and training materials for identifying and reacting to UXO hazards. If you are operating at an unfamiliar location, ask range control, local EOD, or your sponsoring agency if there is any UXO orientation training available specific to this location or installation.

Prior to occupying a training or mission location, be sure to check it for UXO hazards. Quartering party SOPs usually require a sweep of the area to ensure its suitability for occupation. If you are in a known high-risk area, use your available detection equipment before declaring an area safe to move through or occupy. If you are conducting a real-world mission, be sure to get the latest intelligence on the area and its land mine and UXO status from your S-2 and any previous users of the site.

And finally, emphasize to your soldiers during safety briefings not to touch, kick, or otherwise disturb objects found in their environment.

This isn't just a cliché--curiosity killed our sample operator because his leaders did not emphasize UXO hazards to him. Our soldiers deserve better than this. ♦

POC: MAJ Monroe B. Harden, Ground Systems and Accident Investigations Division, USASC, DSN 558-3261 (334-255-3261), hardenm@safety-emh1.army.mil

Attaboy!

Soldier Receives The Army Safety Guardian Award

PV2 Jeremy L. Huffman, 66th Military Police Company, Fort Lewis, Washington, risked his life to save CMS William C. Lomas (AF, Retired) from a fatal train accident.

In January 1998, PV2 Huffman was surveying an area of Fort Lewis when he found CMS Lomas' unoccupied vehicle in a wooded area. A detailed search of the area was made and CMS Lomas was found walking his wounded Labrador Retriever along the rail right-of-way. Both were exhausted. Prior to this, he had spent 4 hours trying to rescue his dog from the waters of Puget Sound. Without warning, a train approached and the dog collapsed on the tracks. CMS Lomas stood on the tracks in the path of the train and attempted to pick up the tired, wet, 132-pound animal.

PV2 Huffman was present at the scene and gave verbal warnings to CMS Lomas; however, he did not respond. Instinctively and with total disregard for his own safety, PV2 Huffman grabbed him and extracted him from the path of the train. The elapsed time from seeing the train and saving CMS Lomas was less than 20 seconds. Through quick action, PV2 Huffman prevented a catastrophic incident. Unfortunately, the dog was struck by the train and killed. ♦

Take No Unnecessary Risk of Life

During his tenure as Chief of Staff of the Army, General John A. Wickham, Jr., was dedicated to safety and accident prevention. General Wickham's commitment to safety was reflected in his Five Point Safety Philosophy. These points are listed below.

- Nothing we do in peacetime warrants unnecessary risk of life or equipment.
- Commanders are safety officers.
- Teach soldiers and leaders a sixth sense of safety.
- Fix accountability for accidents.
- Safety officials must be proactive and aggressive.

These five points are very basic, simple, easy to remember, and quite effective. The key point in his philosophy is the first one--"Nothing we do in peacetime warrants unnecessary risk of life or equipment." The total disregard for this first, and foremost, point of his philosophy is illustrated only too well in the following accident scenario.

The infantry battalion's scout platoon had occupied a range in the local training area in preparation for numerous training events that were to take place over a period of several days. Training on the first day consisted of day and night, dry and blank firing, as well as live-fire operations in preparation for the next day's training. The training was conducted without incident. The second day's training consisted of a hand grenade range and a fast rope live-fire exercise.

Early in the morning of the second day, the lieutenant platoon leader, who was also the range OIC, was informed that another unit was also scheduled to use the same range that day. In an attempt to expedite the training, the lieutenant picked up four M67 fragmentation grenades from the ammo supply point on his way to conduct his leader's recon for the fast rope live-fire exercise. From there, he would go directly to the grenade range. As he headed towards the recon area, he attempted to secure the grenades in the four grenade pouches located on his two ammo pouches. He properly secured three of the four. The fourth was only secured to the pouch by the grenade pouch strap that he had placed through the grenade pin. Upon completion of the recon, he noticed one of the grenades was missing. The grenade pin was still hanging on the grenade pouch strap.

The lieutenant immediately went to find the grenade. He searched for the grenade for two hours without success. He notified his platoon sergeant, also the range safety officer (RSO), and told him of the missing grenade. He instructed the platoon sergeant to continue training. The battalion command sergeant major, who was inspecting training on the range, was informed of the missing grenade and called a cease fire halting all training. He notified range control and the chain of command.

Early that afternoon, Explosive Ordnance Disposal (EOD) personnel arrived on the scene. After viewing the terrain and vegetation where the grenade had been lost, and knowing that the grenade had no safety pin, EOD personnel assessed the risk of searching for the grenade as "extremely high." The EOD detachment commander would not allow his people to search for the grenade or assist the unit in searching for the grenade.

The local range regulation stated that the unit was to cordon off the area, mark it as an impact area, and the area would be burned in the fall. These actions had been completed under the supervision of range control when the word came from the division commander that the unit was to find the grenade. The division commander had not been informed that the grenade was missing the safety pin.

The following day (day 2), the unit initially attempted to find the grenade by cordoning off the area where it was suspected that the lieutenant had lost it. The area was then divided into lanes wide enough for eight soldiers. Standing side by side, the soldiers would slowly walk down the lane, carefully moving each branch and twig, looking for the grenade. This proved to be unsuccessful. Later that day, word came from division headquarters—the general had been informed the grenade had no pin and had told the unit chain of command not to use soldiers to find the grenade, but to use the engineers and EOD to locate the grenade.

The following morning (day 3), an engineer unit attempted to find the grenade using mine

sweepers. The mine sweeper (basically a metal detector) is employed by swinging it back and forth over low-cut or barren terrain. The vegetation where the grenade was lost is over ten feet high and so thick a human can hardly walk through it. Due to the vegetation, the mine sweepers could not be used. In attempt to assist in the employment of the mine sweepers, the infantry soldiers were told to cut down the vegetation. They put on their fragmentation vests and kevlar helmets, were issued axes, machetes, sickles, and scythes, and went back in the area to cut the vegetation. The operation continued uneventfully for the rest of the day.

Early on the morning of the fourth day, the brigade commander arrived at the range and briefed the soldiers. Part of his briefing included how to properly cut the vegetation in order to locate the grenade. After he briefed the soldiers, he departed the range and the soldiers again began cutting the vegetation. Ten minutes after the brigade commander left the range, the grenade exploded.

As the grenade exploded, the battalion commander, the platoon leader, and platoon sergeant were huddled together discussing the situation. A young specialist was walking down the hill towards them with an axe. The specialist did not have his fragmentation vest properly closed and a small grenade fragment pierced his heart killing him instantly. The battalion commander's left foot and lower left leg were so badly injured that his leg had to be amputated below the knee. The lieutenant and staff sergeant received multiple shrapnel wounds and seven other soldiers who were within 12 feet of the blast also received shrapnel injuries.

As you read the accident scenario, I hope you visualized the situation. A lot of questions come to mind but the main question is, "Why were soldiers' lives risked to find a grenade that did not have a pin in it?" They continued the search even after EOD personnel informed them of the risk in searching for the grenade. As you complete your risk assessment for your operations in garrison or the field, keep one thing in mind, "Nothing we do in peacetime warrants unnecessary risk of life or equipment." ♦

POC: CW4 Gary D. Braman, Training Branch, USASC, DSN 558-9197 (334-255-9197); bramang@safety-emh1.army.mil

Other Grenade Safety Considerations

■ Treat any thrown grenade that fails to detonate as a dud, regardless of safety pin, safety clip, or safety level status.

■ Don't tamper with any thrown grenade. Call Explosive Ordnance Disposal (EOD) for assistance.

■ Observe caution with grenades that have igniting type fuses. These grenades ignite with a flash and should be thrown at least 10 meters from all personnel.

■ Consider all duds as dangerous. Follow these procedures:

—M69 Practice Grenade. Wait 5 minutes before defusing. Keep bottom of grenade oriented in safe area. Place dud fuse in a sand-filled container and return to issuing facility.

—Fragmentation Grenade. Thrower and supervisor should wait in throwing pit for five minutes before returning to covered area. Notify EOD immediately. Do not throw any hand grenades into area until dud is neutralized. If range permits, continue training on adjacent impact areas separated by berms.

■ Know what to do in case of a dropped live hand grenade.

■ Conduct a risk analysis and put in place every control necessary to conduct training safely.

■ Use checklist in FM 23-30, Appendix B, Live Hand Grenade Range Operations, to assist in educating leaders and range personnel on how to safely conduct hand grenade training.

■ If in doubt, consult FM 23-30, Grenades and Pyrotechnic Signals. ♦

POC: CW3 Juan Convers, Ground Systems Division, USASC, DSN 558-2966 (334-255-2966), conversj@safety-emh1.army.mil

Crash Course In Seatbelts

My buddy and I left home on a Saturday morning to go play a round of golf. It was finally our day off and it looked like a great day to be outside. We washed and waxed the car to perfection and then hopped in to drive to the post golf course, which was only a few blocks away. It only took a few minutes to get there, so no seatbelts were used. Riding along in my nice clean car, we were engrossed in a conversation about—what else? Golf! That great shot I had made last week on hole number 5 was spectacular! All of a sudden, just out of the blue, a tree came out of nowhere--

WHAM!

My vehicle came to an abrupt stop.

My beautiful car! My buddy. My family. My future. My life--gone in less than a second.

I remember coming to with people all around me. I was in the hospital. My mother was holding my hand and calling my name. Other people were there also—people dressed in white that I didn't know. My head felt heavy and I just wanted everyone to go away so I could go to sleep. My eyes finally found the darkness.

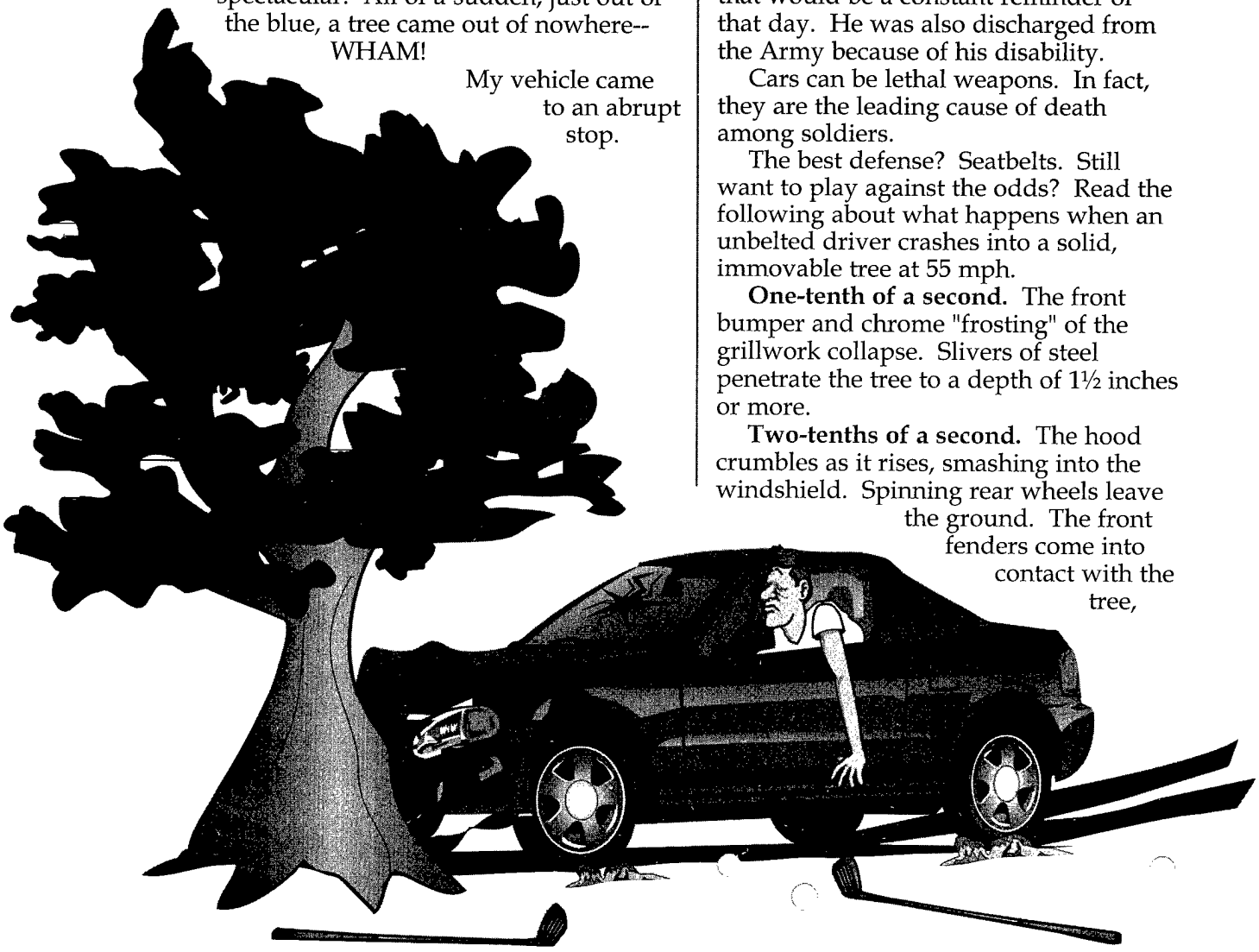
I became a statistic that day. My buddy lived, but he had a severe limp that would be a constant reminder of that day. He was also discharged from the Army because of his disability.

Cars can be lethal weapons. In fact, they are the leading cause of death among soldiers.

The best defense? Seatbelts. Still want to play against the odds? Read the following about what happens when an unbelted driver crashes into a solid, immovable tree at 55 mph.

One-tenth of a second. The front bumper and chrome "frosting" of the grillwork collapse. Slivers of steel penetrate the tree to a depth of 1½ inches or more.

Two-tenths of a second. The hood crumbles as it rises, smashing into the windshield. Spinning rear wheels leave the ground. The front fenders come into contact with the tree,



forcing the rear parts out over the front door. The heavy structural members of the car begin to act as a brake on the terrific forward momentum of the 2½-ton car. But the driver's body continues to move forward at the vehicle's original speed—20 times the normal force of gravity; his body now weighs approximately 3,200 pounds. His legs, ramrod straight, snap at the knee joints.

Three-tenths of a second. The driver's body is now off the seat, torso upright, broken knees pressing against the dashboard. The plastic and steel frame of the steering wheel begins to bend under his terrible death grip. His head is now near the sun visor, his chest above the steering column.

Four-tenths of a second. The car's front 24 inches has been demolished, but the rear end is still traveling at an estimated speed of 35 mph. The body of the driver is still traveling 55 mph. The rear end of the car, like a bucking horse, rises high enough to scrape bark off low branches.

Five-tenths of a second. The driver's near-frozen hands bend the steering column into an almost vertical position. The force of gravity crushes his chest against the steering wheel, rupturing arteries. Blood spurts into his lungs.

Six-tenths of a second. The driver's feet are ripped from his shoes. The brake pedal shears off at the floor board. The chassis bends in the middle, shearing body bolts. The driver's head smashes into the windshield. The rear of the car begins its downward fall, spinning wheels digging into the ground.

Seven-tenths of a second. The entire writhing body of the car is forced out of shape. Hinges tear, doors spring open. In one last convulsion, the seat rams forward, pinning the driver against the cruel steel of the steering shaft. Blood leaps from his mouth; shock has frozen his heart. The driver is now dead.

Elapsed time: only seven-tenths of a second.

Wearing seatbelts and encouraging others to wear them shows you care. Fastening your seatbelt should be as automatic as turning on the ignition. Take the time to develop the seatbelt habit. Sure, buckling in takes a few seconds...but the one time that you don't—could be the one time you wish you had. ♦

PLEASE BUCKLE UP, IF NOT FOR YOURSELF, FOR YOUR LOVED ONES.

Remember it's the law! Soldiers are required to use seatbelts anytime they are driving or riding in a military vehicle or POV. The regulation applies even in the absence of a state law to wear seatbelts. It includes both on and off military installations. Nearly 45 percent of all fatalities involving vehicles could have been prevented if seatbelts were worn. Army Regulation 385-55 sets the standard; first-line leaders must enforce it.

Editor's note: Has your seatbelt saved your life or the life of a friend or loved one? If so, please tell us about it. We'd like to publish your stories. Send them to: U.S. Army Safety Center, ATTN: CSSC-OG (Countermeasure), Fort Rucker, AL 36363-5363 or email countermeasure@ safety-emh1.army.mil

From The Troops

Risk Management of Washrack Operations

Note from the editor: Risk management was first introduced to the Army safety community 11 years ago and has evolved into the Army's doctrinal force-protection process for preserving combat power and increasing combat readiness. Risk management is not complicated. We as safety professionals need to do a better job of getting the word out when we hear of effective safety programs in the field. Countermeasure wants to share this proactive safety information with the rest of the Army. Here is how one installation risk-managed a significant problem by implementing a strong prevention program.

Cold weather was a primary concern throughout Operation Joint Endeavor. The high levels of snow, cold temperatures, freezing rain, and prolonged exposure to weather put the soldiers at a higher risk for cold-weather injuries. To control this risk, a strong cold-weather injury prevention program was in place during the deployment and sustainment phases of the operation. Next, the concern focused on the redeployment.

Risk management was used extensively throughout the deployment and sustainment. The use of risk management was also well integrated and was being adapted for specific situations. As the preparation for redeployment began, the need for risk management was apparent.

Redeploying units went through a seven-day process at the Intermediate Staging Base (ISB) in Taszar, Hungary. One phase of the process was to wash and clean all vehicles and containers for shipment to Germany, and for some units through customs inspection for return to the United States. The soldiers and leadership of the redeploying unit were required to properly operate the equipment in the washrack and follow all risk management control measures as they washed their vehicles and equipment. Due to the time constraints, washrack operations needed to be conducted day and night in all types of weather. With this in mind, the hazards of cold-weather injuries and the potential for accidents on icy surfaces had to be identified and controlled.

There were a number of key players in the operation of the washrack. They included the Commander of the 7th Combat Support Group, Commander of the 71st Combat Support Battalion who ran the base operations, Commander of the 345th RAOC who ran the washrack, 7th Combat Support Group safety representatives and unit safety personnel, preventive medicine personnel, personnel from the 27th Transportation Battalion who provided container movement, and the Brown and Root Contractor who operated the washrack operation. These key players came together to form a cohesive team that focused on improving the hazard control program and reduce risks. The 7th Combat Support Group commander ensured all actions were coordinated and hazard information went through the chain of command to the user.

The S-3 for the 7th Combat Support Group used the traditional risk-management process to develop the mission of washing vehicles so that it included controlling cold-weather injuries and accidents. First, a mission statement was developed and a diagram of the washrack operation was completed. Through risk management, hazards were identified, a risk assessment checklist was developed, and precautionary measures to reduce the risk were identified. This information was used to educate personnel who worked in the washrack daily, as well as transient personnel of deploying units on the hazards and control measures to prevent cold-weather injuries and accidents.

Two particular products were developed as a result of this risk-management process that applies to washrack operations conducted in cold weather. The first is the Cold Weather Exposure Guide (see top chart on page 11). This is basically a hazard control matrix that compares the temperature with cold-weather equipment and clothing. By looking down the left side of the chart, one can locate the temperature during which the washrack operation will take place. This is after wind chill is figured in. By moving right from the approximate or forecast temperature at the washrack, one can identify the specific items of clothing required and the maximum amount of time a person should be exposed to the cold weather by operating a hose

or steam cleaner. This is a quick and easy guide that anyone can use. To reduce the risk of cold-weather injuries, soldiers are required to wear the appropriate clothing items and not work for more than the time indicated to keep the risk at a low level.

The second product is a washrack authorization chart (see bottom chart). This matrix takes the risk associated with the ice, snow, and temperature and identifies the approval authority that must accept the risk and authorize the washrack to operate. By identifying the weather conditions in the right three columns that resemble those present or that will be present at the time, one can move left to column one and determine the overall risk for the operation. Green is low, amber is moderate, red is high and black is extremely high. The leader in charge of the washrack must then obtain the authorization of an individual in the chain of command in the grade of column two to operate the washrack. If weather conditions degrade and the risk increases, the officer in charge of the washrack must stop operation until a leader of the appropriate grade in column two accepts the risk and authorizes the operation to start again.

This is one example of a risk-management application that was developed by leaders to control and eliminate hazards and allow an operation to be conducted with the minimum risk possible. The fact that this was done during a real-world mission during times of high stress should not come as a surprise. This is how risk management is supposed to work and exactly how today's leaders can reduce risks while accomplishing difficult and dangerous missions. Protecting the force is every leader's responsibility. ♦

This article was authored by MAJ Doug Evans, 7th Corps Support Group, DSN 314-469-7134, 7csgdepcdr@7csg.bamburg.army.mil and Fred Fanning, CSP, Maneuver Support Center and Fort Leonard Wood, DSN 581-1275, fanningf@wood .army.mil

COLD WEATHER EXPOSURE GUIDE

FAHRENHEIT	CLOTHING REQUIREMENTS	EXPOSURE TIME
50°	BDU'S WET WEATHER GEAR	4-HR
40°	WET WEATHER GEAR ECWCS[1] (OPTIONAL LAYERING)	2-HR
30°	WET WEATHER GEAR ECWCS (LAYER 1[2] MANDATORY)	1-HR
20°	WET WEATHER GEAR ECWCS (LAYERS 1 & 2[3] MANDATORY)	30-MIN
10°	WET WEATHER GEAR ECWCS (LAYERS 1 & 2 MANDATORY)	15-MIN
0°		

1. Extended cold-weather clothing system.
2. Layer 1= Polypropylene undershirt and drawers.
3. Layer 2=Bib overall, cold-weather shirt, and trouser liner.

WASHRACK OPERATIONAL CONDITIONS

STATUS	RISK {AUTH}	ICE	SNOW	TEMP
BLACK (Prohibitive)	Extremely High {0-7}	SHEET	DRIFT	<10°F
RED (Restricted)	High {0-6}	PATCHY	PACKED	10-32°F
AMBER (Caution)	Moderate {0-5}	PATCHY	LIGHT	32-40°F
Green (Normal)	Low {OPS}	NONE	NONE	>40°F

Take No Unnecessary Risk

What about trying a little risk management in your everyday life? Any time you're tempted to try something out of the ordinary, ask yourself this simple question: "What is the worst thing that can happen to me if I do this?" If the answer is "maimed, destroyed, ruined, broken, wasted, drowned, wrecked, burned, infected, or dead—

PLEASE DO SOMETHING ELSE!"