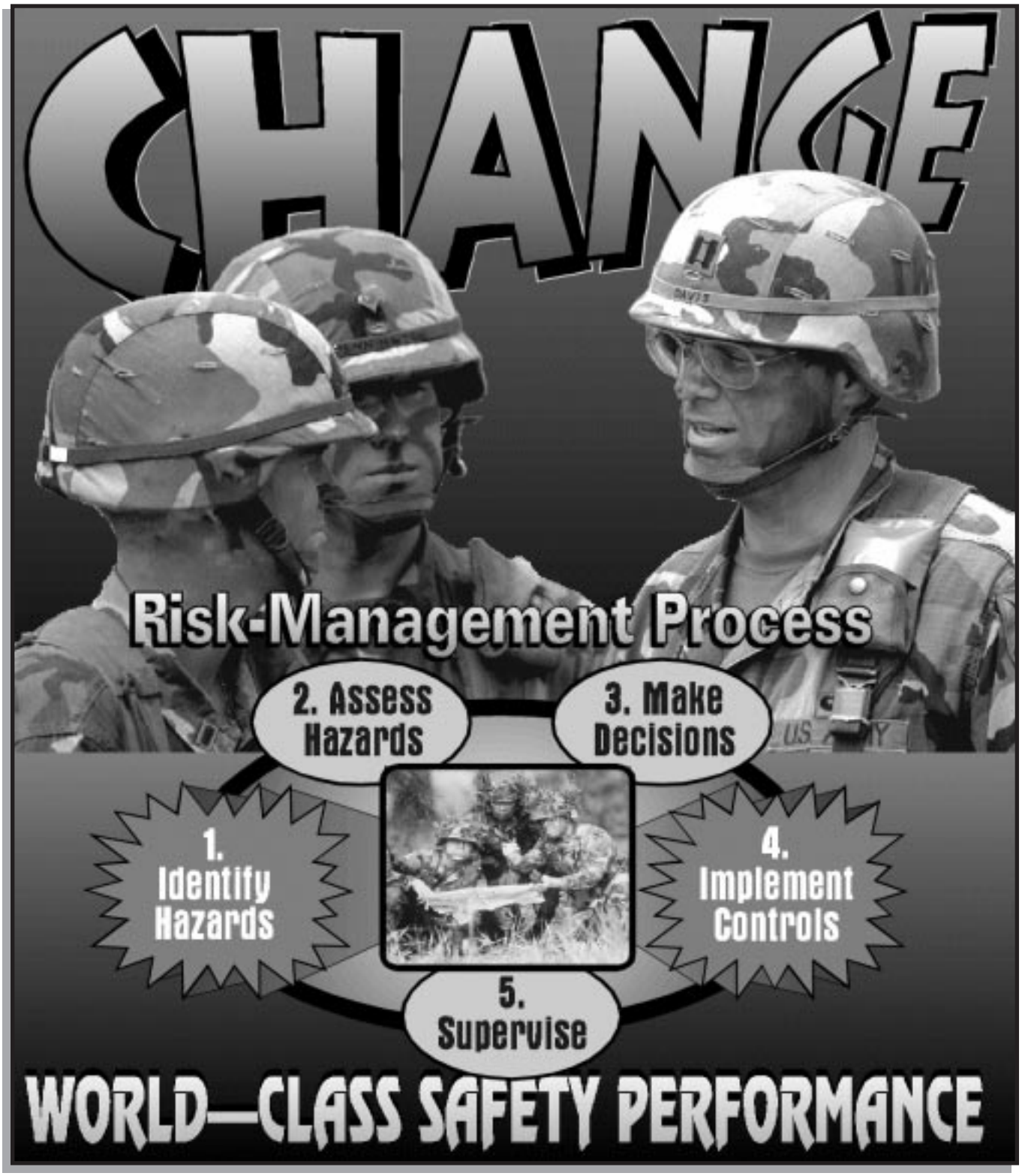
ARMY GROUND-ACCIDENT REPORT

COUNTERMEASURE

Volume 18 Number 1 January 1997



The challenges of change

Change. The Army's gone through a lot of it in the past 5 years. We've become a new force, a smaller force, a force that not only defends the nation militarily but also takes on new, nontraditional missions. And much of the time, we conduct operations as part of a joint and combined force. We've transitioned from a forward-deployed, forward-defense, major-land-war Army to a CONUS-based, contingency-force-oriented, crisis-response Army that must prepare to react to uncertain threats.

The new reality

All this is now reality. It's not just coming, it's here. The radical changes we're dealing with as well as those we have yet to face require corresponding changes in the way we look at doing our business. Why? Because one thing has not changed: accidents are still a major threat. And, as the Army has shrunk in size even as our missions have grown, every accident has become more expensive not only in terms of manpower and money, but also in terms of readiness.

Today, more than ever before, every mission requires precise evaluation, precise planning, and precise execution. Risk-management integration into all three is the key to protecting the force.

We have a simple risk-management process that we can apply to everything we do. All we have to do when we receive a mission is work the hazards and controls in the five-step process:

Step 1. Identify hazards.

Step 2. Assess hazards.

Step 3. Develop controls and make risk decisions.

Step 4. Implement controls.

Step 5. Supervise and evaluate.

Simple, right? So how come we're not all doing it? It has to do with our culture.

Our cultural dilemma

Some aspects of Army culture effectively exclude the risk-management process. After all, risk management leaves no place for—

- The "Hooah Factor," the "We can do any thing, any where, any time, at any cost" attitude that's so much a part of our Army culture.
- The need to "do more with less" mindset.
- Our inbred reluctance to say "No."
- Making decisions based on "the way we've always done it."
- Letting "somebody else" worry about the hazards involved in our missions.
- Doing only what we *have to do* and not giving a thought to what we *ought to do*—such as wearing flak jackets in all live-fire training even when it's not required by regulation. In other words, doing the harder right versus the easier wrong.

The solution to this cultural dilemma seems to be pretty straightforward: change the culture.

Can we change our culture?

Absolutely we can. And it doesn't have to take forever. We've made some huge changes in our culture during the relatively recent past. We've seen—

■ Yesterday's macho image of the hard-drinkin', hell-raisin' soldier replaced by today's image of the responsible, self-disciplined soldier.

■ Yesterday's attitude that accidents are simply the cost of doing the Army's business replaced by today's attitude that accidents are neither necessary nor acceptable.

■ Yesterday's attitude that high risk is inherent in hard, tough, realistic training replaced by today's attitude that risk management enables us to train harder, train tougher, and train even more realistically with less risk.

■ Yesterday's acceptance of a Class A through C ground accident rate of 8.89 per 1,000 soldiers in FY 90 as real progress, replaced by the knowledge that today's rate of 4.02 is still much too high.

So, no, cultural change is not impossible. But it's not going to be easy—for a number of reasons.

Barriers to cultural change

Certain of today's realities stand in the way of our easily changing the way we do business. For example—

■ **Smaller Army with more missions.** Doing more and more with less and less results in little or no time to learn the lessons of the last mission or to adequately prepare for the next. Leaders and their staffs are so busy that they are off planning the next mission while the troops are executing the current one. There's so much to do, we stay with what we know—"*the way we've always done it.*"

■ **Personalities.** We have leaders at all levels whose style it is to say, "I don't want to hear excuses; if you can't do the job, I'll find somebody who can." And there are soldiers of all ranks who simply don't have it in them to tell the boss something he or she doesn't want to hear. And so we are encouraged to stay with what we know—"*the way we've always done it.*"

■ **Competition.** It's a hard thing to point out a problem— especially when nobody else is complaining. Doing so could be perceived as whining and give our peers an edge over us. So we go along, staying with what we know—"*the way we've always done it.*"

■ **Career aspirations.** Today's Army consists of quality competing with quality. May heaven forbid that leaders become more concerned about their careers than about their troops, but the opportunity exists. We all have career aspirations and, therefore, walk a cautious line. As a result, we tend to stay with what we know—"*the way we've always done it.*"

The Army has experienced significant change, creating a cultural dilemma we must overcome.

How do we do it?

Leaders at all levels are responsible to protect the force. They are required to make unencumbered, *conscious* (vice *unconscious*) decisions to either eliminate hazards or accept risks. The mindsets previously discussed are encumbrances to clear decision making. A standard process linked to proactive leadership can be the effective means to overcome our cultural dilemma. Risk management is that process.

"As we become smaller, protecting the force becomes even more important. Risk management...has resulted in a dramatic reduction of injuries and fatalities."

GEN Dennis J. Reimer
Chief of Staff, Army

"The risk-management process enables leaders at all levels to make conscious decisions to either control the hazards or accept the risks."

BG Thomas J. Konitzer
Director of Army Safety

"Applying the risk-management process in conjunction with troop-leading procedures enables NCOs to make the difference between a mission accomplished safely and a mission failed because soldiers were injured or killed."

SGM Gregory L. McCann
Army Safety Center

When it comes to payoff versus effort, consistent use of the five-step risk-management process offers an unparalleled win-win opportunity—a way to get any job done with a clear focus on hazards and controls to mitigate risks. The risk-management process gives us a standard procedure, regardless of mission or force mix or location, to deal with today's realities of uncertainty and high optempo, which demand that—

■ We know and perform to established

standards—every time, in every thing. Using our standard five-step risk-management process is a credible way to challenge and eliminate the "That's the way we do it in *this* unit" mentality and get everybody doing things right—to Army standards.

■ We make effective communication the norm up and down the chain of command. A by-product of the risk-management process will be improved communication as we make it not only *acceptable* but *expected* for everyone involved at every level to articulate to the boss the hazards, controls, and resources required to mitigate the risk of every mission. Risk management becomes the standard way of doing business. It is linking a process with leadership; that's capturing the power of risk management.

■ We make good decisions based on facts, not on fear of being perceived as weak or negative. If we all speak the same language and work the same process of risk management, everybody will understand and no one will mistake the articulation of hazards ("Here's the level of risk for this mission (or task), Boss, and I need your help to bring it down to an acceptable level and still accomplish the mission without any loss") for making excuses ("What's the matter? You can't do it?").

■ We make it not just *acceptable*, but *mandatory*, to tell the boss "No, we can't do that" when risks are too high. If we work the five-step risk-management process at every level, the yes will come—but only after the risks have been controlled to an acceptable level or someone with the proper authority at the proper level makes a *conscious, fully informed* decision to accept that risk.

■ We once and for all destroy the notion that we'll do things differently when the shooting starts, that we'll abandon standards and all that other "training stuff." Risk management is not only an enabler to realistic training, its across-the-board, methodical use will be the best method we have of making sure that the only threat we face in combat is the enemy.

Where do we start?

We start by making risk management—identifying hazards, putting controls in place—the standard way we do business in the Army. So, how do we do that?

We base it on doctrine.

Doctrine is the engine of change in the Army; it drives change not only in training, equipment, and organization but also to a large extent in Army culture—those attitudes and thought processes that make the Army what it is.

This being the case, the catalyst for embedding risk management in our culture is already in our doctrine. FM 100-5: *Operations*, our keystone warfighting text, was significantly updated in 1993 to stress the principles we need to learn and understand to maintain the edge in future theaters of war. A key update was the addition of safety as a component of the protection element of combat power. Safety has also been included in joint-operations doctrine since 1995 (Joint Pub 3-0: *Doctrine for Joint Operations*). That doctrine specifies that protection of the force through the integration of safety into all aspects of planning and execution is crucial to successful operations.

Just as doctrine and policy changes are capturing the top-down approach to risk-management integration, so too TRADOC is working the bottom-up approach through the integration of risk management into officer, NCO, and civilian schools. All that's left is for the field to shoot to the middle and *just do it*, just integrate risk management into all that we do.

Summary

The Army has done remarkably well in reducing accidents, thus saving lives—especially in the past few years even as global responsibilities have increased. A combination of factors has had a direct impact on this success. First and foremost is proactive leadership at all levels. Second is the fact that we have clear and achievable standards for every individual and collective task soldiers are required to perform. Third is teamwork. It is the essence of how we do business. The fourth is the information flow to enhance communications between decision makers. These four elements are institutionalized throughout our Army today. The fifth ingredient that needs to be institutionalized is a process—the risk-management process. Once embedded as a systems approach to business, we can consistently achieve world-class safety performance.

We must embrace risk management as a sound investment in readiness, not as just another "safety requirement" that has nothing to do with our *real* mission. The true cost of our failure to protect the force through risk management will be paid out of lives and equipment—and thus out of readiness.

And that's a price we simply cannot afford to pay. ♦

—BG Thomas J. Konitzer, Director of Army Safety and Commanding General, U.S. Army Safety Center, DSN 558-9360 (334-255-9360), konitzet@rucker-safety.army.mil.

Near misses

Editor's note: In the December issue of Countermeasure, General Thomas J. Konitzer, Director of Army Safety, acknowledges the difficulties of doing more and more with less and less and the impact this can have on accident reporting. But he also emphasizes how important accident reporting is to our ability to identify hazards and provide controls to prevent similar accidents from happening.

In this issue, General Konitzer's article on cultural change points out that a smaller Army with more missions can result in little or no time to learn the lessons of the last mission because leaders and their staffs are busy planning the next mission while the troops are executing the current one.

These are some of the reasons why we think it is important to publish the article about the near rollover of an M577 at Fort Sill. This unit had done some things right; they needed to work on some others. But the important thing is that Fort Sill publicized what happened. As a result, when another rollover occurred, the second unit had taken note of the lessons learned in the previous accident. They had identified hazards, developed and implemented controls, and rehearsed. The controls were in place, the unit had performed good rollover drills, and the driver was wearing his seatbelt. The crew walked away with no injuries.

These are the kind of lessons learned that we need to share with the rest of the Army. There could be a unit in Germany or one in Korea or one somewhere in the Army that could benefit from this information. And that is why we need to know about the accidents and we need to know about the near misses—so that every soldier in every unit across the entire Army can benefit.

The fallacy in accident statistics is that we haven't found a way to capture the non-recordable accident—the one where no one was killed or seriously injured and equipment damage wasn't enough to require it to be recorded. Does that mean that these near misses aren't important? Not on your life! This is the kind of accident that except for the grace of God (or call it luck if you wish) someone would have lost their life or a piece of equipment would have been destroyed.

Just such an accident happened at Fort Sill when a track shoe broke and an M577 Command Post Carrier partially flipped over with five crewmembers inside. Except for the trailer—which dug into the ground, its front wedged against the M577, preventing it from completely overturning—the outcome might have been quite different.

As related by the crewmembers, it was bad enough. Two of them managed to crawl out of the overturned track vehicle. When two NCOs who were preparing a road block reached the M577, they found another crewmember's leg was trapped under a field desk. As they helped free him, the track commander was helping still another crewmember out of the vehicle. None of the crew were seriously hurt. But that wasn't what they thought was going to happen when they heard a loud crack, and the tracked vehicle began drifting to the right. The left track had come off, and the driver couldn't stop the vehicle. The track commander, who was riding with his upper torso out of the TC hatch saw the

Recent accidents similar to the M577 at Fort Sill reveal the following common factors:

- Soldiers driving too fast for conditions
- Poor maintenance
- Drivers who are poorly trained or lack experience
- Soldiers operating vehicles in unfamiliar environments

Controls:

Protecting our force involves tough, realistic training coupled with risk controls that protect soldiers in training and in combat. It is the responsibility of the first-line leader not only to help set those standards but also to enforce them.

rollover coming. He yelled "Get down, hang on!" and dropped. The driver had only seconds to lower himself inside the vehicle, and all he could think about was that he would be crushed by the vehicle's weight. As the vehicle tilted, the field desk, safe, and crewmembers were piled on top of each other, and a track crew's nightmare, fuel, was pouring over them.

When movement stopped, the soldiers didn't know if the vehicle was stable or if it would come crashing down on them as they crawled out the track commander's hatch, located in the middle of the vehicle—but they made it.

"My instructor in AIT used to tell us to watch for those tracks flipping, I used to laugh and think it would never happen to me...it happened," said one crewmember.

The cause

MAJ John Stephens of the Force Protection Office said "The track shoe broke. The bushings appeared to have worn, which caused undue stress. It was obviously a materiel failure, but one that could have been caught."

Controls

■ *Those they used*

- Crewmembers were all wearing protective headgear.
- Tiedown plan was pretty good.
- Driver did as good a job as possible with a runaway track headed downhill.

■ *Those they didn't use*

- Driver wasn't wearing his seat belt.

■ *Those they will do better*

- Continue to stress and enforce safety and diligent maintenance.
- Check seatbelt use.
- Practice rollover drills during command maintenance every Monday.
- Make rollover drills a part of pre-combat inspections, convoy briefings, and during command maintenance.

"In many cases, proper emphasis on maintenance, checking tracks, following your dash 10, can prevent track accidents," MAJ Stephens said.

A Battery executive officer, 1LT Brian Waltman said three of the crewmembers are all brand-new soldiers. "They reacted as a team, and that is a credit to them and the training they received in AIT. They were all banged up and bruised, but none were seriously injured." ♦

—adapted from the *Cannoneer*

Near miss for the environment too

When an accident or near accident occurs, something besides the safety of the crew and equipment is at stake.

When an M577 at Fort Sill flipped partially over, fuel poured from the wreckage. Except for the quick action of soldiers and civilians, the fuel would have found its way into a nearby creek, threatening wildlife and vegetation and eventually finding its way into the drinking-water supply.

NCOs on the scene knew what to do and did it—fast. They quickly obtained and put into use "spill kits" designed to minimize the environmental damage. First, they placed a drum underneath the fuel leak, managing to catch more than 15 gallons of fuel. Then they used "socks" or booms in runoff areas to trap the 5 gallons or more of fuel that had spilled and create a containment barrier. These "socks" are like net tubes filled with absorbent material that allows water to pass through but absorbs petroleums, oils, and lubricants. Fire fighters saturated the area with water to dissipate fumes, a necessary precaution because of the potential for sparks from recovery equipment. Once the track was uprighted, the cleanup crew brought in a backhoe, scraped up the contaminated soil, and transported it to the contaminated soil site at the landfill.

Knowing what to do, how to do it, and doing it quickly prevented what could have been serious damage to the environment. ♦

M989A1 HEMAT trailer accident claims life

A soldier was crushed to death when he tried to stop an M989A1 HEMAT trailer, which was rolling down an incline. The soldier was part of a crew assigned to a red-cycle tasking replacing trailer beds. The operation consisted of removing rotted floor boards from the trailers in a holding area, moving them to a motor pool to replace the boards, then returning the trailers to the holding area.

The individual in charge of the operation planned and reviewed the procedures needed to carry out the operation. However, his primary focus was on the steps required to replace the boards—cutting, drilling, and emplacing the boards in the trailers.

Several hazards were identified, but the leader considered the risk of damage to the equipment as more probable than risk to the soldiers who were performing the operation. He identified the hazards to soldiers as potential heat injuries and injuries while operating power tools. He didn't include in his risk assessment such things as crew turnover, moving the trailers manually, and adequacy of the motor pool for conducting such an operation.

The operation had been going on for about a month. The day before the accident, a new crew reported for duty. The project leader briefed them on the operation and checked to make sure all of the soldiers on the detail were able to perform the required tasks. But one soldier was absent from the briefing.

Previous crews had used several methods of positioning the trailers inside the maintenance bays where the work would be done. Because entry into and exit from the bays was restricted, the trailers had to be backed for an extended distance then pushed into place by the soldiers. Just before the accident, the team was pulling trailers into the bay with a HEMTT, then they would disconnect the trailer and move the HEMTT through the bay where, with some difficulty, the vehicle could turn left onto a roadway. Because the turn out of the bay was so tight, the crew couldn't push the trailer directly onto the road after they had finished working on it. So they would push the trailer out by hand, steer it left, and push it over a curb to an area adjacent to the road. As the trailer was maneuvered into place, one soldier

A soldier was killed when this trailer rolled over him while he was attempting to steer it away from parked vehicles. The risk assessment did not cover all aspects of the operation, and controls were not in place that could have prevented this accident.

would steer and another one would push in the emergency brake release handle (located under the left side of the trailer) to stop the trailer. After the trailer came to a stop, a HEMTT would hook up to it and tow it back to the holding area.

The accident

On the day of the accident, the soldier who had missed the safety briefing arrived at the motor pool to work on the detail. He had a medical profile directing no lifting of more than 5 pounds with his right hand.

Just before lunch time, the crew had completed work on a trailer, and it was still sitting in the bay. One soldier went to the motor pool office to order food. When the other members of the detail saw the HEMTT approaching with another trailer, they started moving the one they had just completed out of the bay. Because they were one person short, the soldier with the profile volunteered to steer the trailer by holding the approximately 65-pound tongue. The other soldiers pushed the trailer out of the bay and over the curb, and one of them tried to stop it by pushing in the emergency brake release handle. The vehicle continued rolling and the soldier continued to try to stop it, using the emergency brake release. When he realized the trailer wasn't going to stop, he yelled "No brakes!" and the rest of the crew backed away from the free-rolling trailer.

One of the soldiers yelled that the trailer was headed down the slightly inclined road toward some POVs. At this time, the soldier with the profile ran in front of the trailer to try to steer it away from the POVs. As he grabbed the tongue, he either slipped or was knocked down by the trailer. When he fell to the pavement, the trailer ran over him and he was dragged aproximately 63 feet. The trailer then ran off the road and into a water-filled ditch. The injured soldier received prompt emergency treatment but died of injuries to his head and chest.

Accident causes

The primary causes of this accident were a flawed risk assessment, the soldier's belief that he would be able to control the trailer, and improper procedures with regard to trailer operations. Several other things also stand out about this accident. First, it points out the potential danger during red-cycle taskings with soldiers assigned tasks they aren't trained to do. New people, under a new leader, in a new location are the building blocks of an accident. Second, leaders must scrutinize all aspects of an operation for risk, not just the main task. Last is the need to use equipment for its intended purpose.

—POC: MAJ Julian C. Simerly III, Chief, Ground Tactical Branch, DSN 558-3901 (334-255-3901)

Driver killed when M981 FISTV flips

A soldier was fatally injured when the M981 FISTV he was driving flipped and he was partially ejected from the vehicle. He was not the assigned driver of the vehicle but was orienting the assigned driver during preparation for a field training exercise (FTX) where drivers maneuver Officer Basic Course (OBC) students as they execute tactics, techniques, and procedures (TTPs) learned during instruction.

The primary cause of the accident was excessive speed, but other factors also contributed to the cause and severity of the accident:

- The maintenance section failed to road test the vehicle after service, allowing the track to be operated with an improperly adjusted left lateral.
- There was no record of any PMCS completed in the 8 days the vehicle was dispatched before the accident.
- Two drivers for the exercise had never participated in the exercise before and were unaware of the routes they were supposed to navigate with the student track commanders.
- The victim was not wearing his seatbelt, allowing him to be partially ejected from the M981 as it flipped.

Hazard identification

During this type of exercise, inexperienced OBC students act as track commanders in a scenario.

Drivers follow orders from the students and assist them if they become disoriented during the execution of the exercise. Two of the assigned drivers had never driven for this particular exercise and were not familiar with the routes they were supposed to navigate with the student track commanders. The accident M981 had an improperly adjusted left lateral, which the soldier who was driving did not know about.

Hazard assessment

The NCOIC was off on another tasking, and all officer instructors were involved in a sand-table (terrain-model) rehearsal with the OBC students. The senior enlisted soldier, a specialist, authorized two drivers—a specialist and a private (the victim)—to show the new drivers the routes they would take during the exercise. The specialist and private, who had previously driven for the exercise, decided they would drive the M981s while the inexperienced drivers acted as track commanders.

The accident

Along the route taken by the accident vehicle, the driver had to descend a hill on a paved road, then make a sharp (approximately 135-degree) left turn onto a tank trail.

The designated speed limit for this road is 35 MPH. The military police report estimates the speed of the vehicle at the time of the turn was 27 MPH.

As the driver entered the turn, the track began to skid and then vaulted, partially ejecting the driver from the hatch during the course of the rollover. When the vehicle landed on its top, the driver's head and upper torso were crushed between the vehicle and the ground.

Although the assigned driver had identified a fault with the north-seeking gyro (NSG) he did not identify any non-mission-capable (NMC) faults with the vehicle. During the 8 days the vehicle had been dispatched, there was no record of any PMCS after the initial before-operators check done for dispatch.

During the accident investigation, a technical inspection determined two NMC faults existed before the accident. One of them was an improperly adjusted left lateral, requiring a force of 75 pounds to release the lateral from the second-notch position. The standard cited in the TM is 10 to 30 pounds. The improperly adjusted left lateral resulted in the vehicle making a sharper left turn than expected when the driver applied normal pressure to the laterals. Coupled with the speed of the vehicle, this caused the track to vault 28 feet through the air. The assigned driver of this vehicle stated that he was aware the left lateral was harder to unlock than the right lateral. ♦

POC: MAJ John Stephens, Field Artillery Branch Force Protection Office, DSN 639-4215

An improperly adjusted left lateral resulted in this FISTV making a sharper left turn than expected when the driver applied normal pressure. This and the vehicle's speed caused it to vault through the air and overturn.

Night jump turns tragic

What was planned as a routine, night airborne operation utilizing the ground marked release system (GMRS), turned tragic for one ARNG paratrooper. The paratrooper, who was the primary jumpmaster, drifted approximately 800 meters from the intended point of impact and was killed when he landed in a set of high-tension power lines.

Hazard identification

The mission was a night, zero-illumination, static-line paradrop operation—involving multiple jumpers—into a small drop zone (DZ) with a known hazard (high-tension wires). Drop altitude winds were greater than expected.

Hazard assessment

The hazard (airborne operations in the vicinity of high-tension power lines) was identified but not communicated. It was not marked on the survey and was not briefed to the jumpers.

When the hazard was identified and assessed, the risk-assessment moved up to the high-risk category, but no additional action was taken.

Controls

Even though FM 57-220: *Static Line Parachuting Techniques and Training* gives two options for determining wind velocity, when units set up or establish a drop zone for any airborne operation utilizing the GMRS, they should, as recommended by FM 57-220, utilize the pilot balloon system (PIBAL) to determine the mean effective wind (MEW). The MEW is the constant wind-speed average from drop altitude to ground surface. The wind speed and direction at drop altitude, or the MEW, should be taken and utilized when determining the desired release point. This reading is taken from the desired point of impact for the No. 1 jumper.

Units that use the second option, which is based on surface wind speed and direction only, are setting jumpers up for the inevitable—off-drop-zone landings.

FM 57-220 and FM 57-38: *Pathfinder Operations* explain the procedures for establishing a drop zone utilizing the GMRS and provide a list of necessary equipment. Units can reduce the probability of injury to jumpers from missing the drop zone by using the GMRS method. Furthermore, units should always review the drop-zone survey and conduct a reconnaissance of the drop zone to confirm or identify any additional hazards that may be present that were not there or were not identified when the survey was initially conducted and approved. ♦

A. Intended point of impact. B. The paratrooper struck high-tension power lines that were not marked on the survey or briefed to the jumpers.

POC: MSG James D. Cobbler, Infantry NCO, Force Development/Force Projection Branch, 558-2933 (334-255-2933)

Safety messages

Following is a recap of safety-of-use messages (SOUM), ground precautionary messages (GPM), and maintenance advisory messages (MAM) issued during 4th Quarter FY 96.

Communications-Electronics Command (CECOM)

Note: Article in December 1996 *Countermeasure* regarding lithium sulfur dioxide battery venting incidents states that GPM 96-012, BA-5800/U (NSN 6665-99-760-9742), lithium sulfur dioxide batteries and GPM 96-013, BA-5590/U lithium sulfur dioxide non-rechargeable batteries (NSN 6135-01-036-3495) consolidate and supersede all previously issued battery GPMs.

■ AMSEL-SF-SEP, subject: GPM-96-007, BB-558/A (NSN 6140-01-186-8802) nickel cadmium battery manufactured by SAFT America, Inc., all contracts, used in the OH-58D aircraft (NSN 1520-01-125-5476). POC: Mr. David Kiernan, DSN 992-0084 ext. 6447.

■ AMSEL-SF-SEC, subject: GPM-96-008, small lightweight global positioning system receiver (SLGR), AN/PSN-10. POC: Mr. David Kiernan, DSN 992-0084 ext. 6447.

■ AMSEL-SF-SEC, subject: GPM-96-009, AN/ALQ-144A(V) infrared countermeasures (IRCM) set (NSN 5865-01-299-5859/60, LIN J01916). POC: Mr. Thomas Brennan, DSN 992-0084 ext. 6404.

■ AMSEL-SF-SEC, subject: GPM-96-009 followup, AN/ALQ-144A(V) infrared countermeasures (IRCM) set (NSN 5865-01-299-5859/60, LIN J01917). This message supersedes and rescinds GPM 96-009. POC: Mr. Thomas Brennan, DSN 992-0084 ext. 6404.

■ AMSEL-SF-SEP, subject: GPM-96-010, BB-5800/U (NSN 6665-99-760-9742) lithium sulfur dioxide battery manufactured by Power Conversion, Inc. (PCI), contract DAAB07-94-D-E002. POC: Mr. David Kiernan, DSN 992-0084 ext. 6447.

■ AMSEL-SF-SEC, subject: GPM-96-011, small lightweight global positioning system receiver (SLGR), AN/PSN-10. POC: Mr. Philip Klimek, DSN 992-0084 ext. 6437

Following is the status of open and previously opened CECOM messages.

■ AMSEL-SF-SEP, subject: GPM-96-001, BB-558/A (NSN 6140-01-186-8802) nickel cadmium battery manufactured by SAFT America, Inc., all contracts, used in the OH-58D aircraft (NSN 1520-01-125-5476). Status: closed. POC: Mr. David Kiernan, DSN 992-0084 ext. 6447.

■ AMSEL-SF-SEC, subject: GPM-96-003, electronic shop, AN/ASM-189C (NSN 4940-01-274-9959, LIN H01855), mandatory, operational. Status: closed. POC: Mr. Wil Vega, DSN 992-0084 ext. 6407.

■ AMSEL-SF-SEC, subject: Followup to SOUM (CECOM 92-02-01, modification work order (MWO), mandatory, operational, OE-254 antenna ground (NSN 5985-01-063-1574, LIN A79381). Status: closed. POC: Mr. Wil Vega, DSN 992-0084 ext. 6407.

■ AMSEL-SF-SEC, subject: GPM-96-005, all hydrogen- filled meteorological balloons. Status: closed. POC: Mr. Philip Klimek, DSN 992-0084 ext. 6437.

■ AMSEL-SF-SEP, subject: GPM-96-006, AN/VRC-12 VHF radio set series installation. Status: closed. POC: Mr. Andrew Burbelo, DSN 992-0084 ext. 6415.

■ AMSEL-SF-SEC-V, subject: SOUM-95-001, S-389/MSA-34 shelter, electrical equipment (NSN 5410-00-988-0302). Status: open. POC: Mr. Vernon Vondera, DSN 229-7192.

Armament and Chemical Acquisition and Logistics Activity (ACALA)

No SOUMs were issued by ACALA during 4th Quarter FY 96. Following is a list of GPMs issued by ACALA.

■ AMSTA-AC-CTTE, 311252Z Jul 96, subject: GPM ACALA No. 96-04, technical, cleaner, steam, high-pressure, hot and cold water jet, diesel-fuel fired, 200 gallon per hour (GPH), trailer mounted (NSN 4940-01-025-9856, LIN C32887), 200 GPH skid mounted (NSN 4940-00-186-0027, LIN E32466), 600 GPH skid mounted (NSN 4940-00-473-6218, LIN E32525). POC: Mr. Lonnie E. Griffin, DSN 793-1947 (309-782-1947).

■ AMSTA-AC-FAPN, 061206 Aug 96, subject: GPM ACALA No. 96-05, M109 self-propelled howitzers (NSN 2350-01-031-0586, 2350-01-031-8851, 2350-01-277-5570, 2350-01-281-1719, LIN

K57667, 2350-01-305-0028, LIN H57642) and field artillery ammunition support vehicle M992 (NSN 2350-01-110-4660), M992A1 (NSN 2350-01-352-3021), M992A2 (NSN 2350-01-368-9500) LIN C10908, MK19 mod-3 grenade machine gun (NSN 1010-01-126-9063, LIN M92362), MK64 mod-7, mount, machine gun (NSN 1010-01-179-7616, LIN M74823). POC: Mr. Gary Rogers, DSN 793-0030 (309-782-0030).

■ AMSTA-AC-SF, 192134Z Sep 96, subject: GPM ACALA No. 96-06, removal and disposal of M16/M16A1 rifle low-light, tritium front sights. POC: Mr. Tim Mohs, DSN 793-6228 (309-782-6228).

Following are SOUMs, GPMs, and MAMs issued during 1st Quarter FY 97

Tank-Automotive and Armaments Command (TACOM)

■ AMSTA-IM-O, 251611Z Nov 96, subject: SOUM TACOM-WRN Control No. 97-01, "limited operational" for M1A2 Abrams tank (NSN 2350-01-328-5964, LIN T13305) using mine-clearing blade system (NSN 2590-01-230-8862, LIN B71632) and mine roller system (NSN 2590-01-134-3724, LIN R11006). Reference SOUM TACOM-WRN Control No. 96-15, DTG 301846Z May 96. POCs: Mr. Mike Calleja, DSN 786-6848 (810-574-6848) and Mr. Byron Polen, DSN 786-7375 (810-574-7375).

■ AMSTA-IM-O, 111902 Oct 96, subject: GPM TACOM-WRN Control No. 96-12, crane 25-ton (NSN 3810-00-018-2021, model MT250, LIN F43429); crane 25-ton (NSN 3810-01-054-9779, model TMS 300-5, LIN F43429); crane 20-ton rough terrain (NSN 3810-00-275-1167, model M320RT, LIN F39378). Reference GPM TACOM-WRN Control No. 96-11, DTG 031238Z Sep 96. POCs: Mr. Roy Rogers and Ms. Gwen Shaffer, DSN 786-7350 (810-574-7350).

■ AMSTA-IM-O, 111809Z Oct 96, subject: MAM TACOM-WRN Control No. 96-013, service brake proportioning valve and serpentine belt drive system used on the XM1114 up-armored HMMWV (NSN 2320-01-413-3739, LIN Z62630). POCs: Mr. Allan Yasoni, DSN 786-8068, or Mr. John Kaminske, DSN 786-8060.

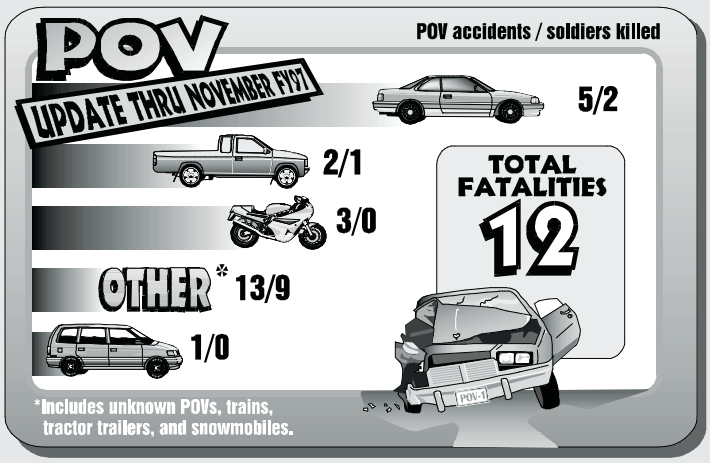
Armament and Chemical Acquisition and Logistics Activity (ACALA)

■ AMSTA-AC-AS, 252021Z Oct 96, subject: MAM TACOM-ACALA 97-03, alternate lubricants for the MK19 mod-3, 40mm, grenade machine gun (GMG) (NSN 1010-01-126-9063, LIN M92362). POC: Mr. Michael Lopez, DSN 793-0033 (309-782-0033).

■ AMSTA-AC-CTC, 261131Z Nov 96, subject: MAM TACOM-ACALA 97-06, concerning shelf-life extension for M273 maintenance kits and M293 maintenance kit availability. POC: Ms. Denise Stewart, DSN 793-6598 (309-782-6598).

Aviation and Missile Command (AMCOM), formerly Aviation and Troop Command (ATCOM)

■ AMSAT-D-WS, 101500Z Oct 96, subject: MAM ATCOM 96-020, official interim instructions for mounting the AR2 automatic ripcord release (NSN 1670-01-369-7914, LIN N/A) on the MC-4 RAM air parachute (NSN 1670-01-306-2100, LIN P68275). POC: Mr. Gayle Sappington, DSN 693-3997 (314-263-3997). ♦



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