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ARMY GROUND RISK-MANAGEMENT PUBLICATION

# COUNTERMEASURE

VOL 19 NO 9

<http://safety.army.mil>

SEPTEMBER 1998

## Human Error Leads Accident Causes

**L**et's look for a minute at this thing we call "human error." When human error is cited as an accident cause factor, it does not necessarily mean that the individual soldier bears responsibility. The soldier could have been set up for failure by inadequate training, standards, support, and/or leadership.

The bottom line is that human factors at every level of the Department of the Army can influence mission outcomes for the individual soldier.



Safety statistics can reflect one of two things—a good news story or a bad news story. However, when one looks at the statistics, one tends to look at only the bad news. That is because we are looking at the accidents that have already happened. I want to pass to you good news: The Army is at a 10-year low for soldiers killed while on duty and doing their job. Why? We have quality soldiers who are doing demanding jobs under demanding conditions and doing them well. We have professional NCOs and officers who know the standards, enforce those standards, and ensure their soldiers follow the standards. It makes a difference. My compliments!

—BG Burt S. Tackaberry, CG, U.S. Army Safety Center



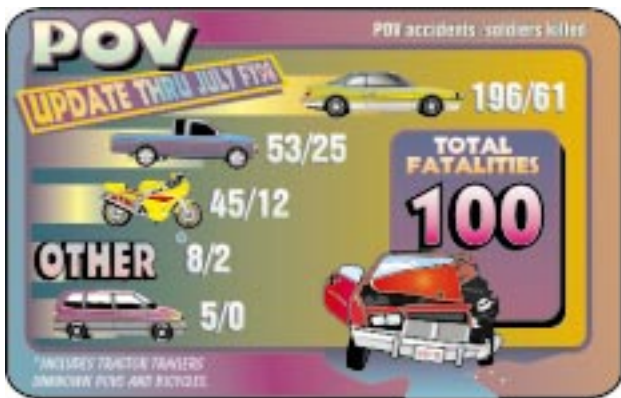
ARMY GROUND RISK-MANAGEMENT PUBLICATION  
**COUNTERMEASURE**

**The Official Safety Magazine for Army Ground Risk-Management**

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Countermeasure is published monthly by the U.S. Army Safety Center, Fort Rucker, AL 36362-5363. Information is for accident prevention purposes only and is specifically prohibited for use for punitive purposes or matters of liability, litigation, or competition. Address questions about content to DSN 558-2688 (334-255-2688). To submit information for publication, use Fax 334-255-9528 (Ms. Paula Allman) or e-mail countermeasure@safety-emh1.army.mil Address questions about distribution to DSN 558-2062 (334-255-2062). Visit our website at <http://safety.army.mil>

**Burt S. Tackaberry**  
 Brigadier General, U.S. Army  
 Commanding Officer

# Director's Corner



**T**he soldier is the heart of our Army...and unfortunately, soldiers make errors. We do not intend to do it, we wonder why we did it, and too often we do it again. Why do we make these blunders? Some of those reasons escape control, but the majority can be controlled.

There are many basic causes of human-error accidents. One is individual failure, in which lack of self-discipline is one of the most common causes. Studies show that the soldier who is going to have an accident is often the one who knows the standards, but elects not to follow them.

Many times, soldiers choose to not follow rules, regulations, standards, or laws. Examples of this is the soldier who knowingly operates equipment in a manner for which it was not designed, or the driver who fails to follow convoy procedures, speed limits, safety belt regulations, or some other operating procedure such as performing before-, during-, and after-operations checks. Identifying this soldier before making him part of the operating system is the most effective way of reducing the chances of a human-error accident.

Other causes of human-error are leader, training, standards, and support failures. Often, these can be tied in some way to leaders who fail to train to standard and fail to enforce those standards. When you see soldiers performing unsafe acts, **stop them**. Make on-the-spot corrections every time you see a safety violation. If uncorrected, it may lead to injury or death. And leaders who accept those errors lower the standards in their units. The solution is simple: **Don't allow the standard to be lowered.**

—BG Burt S. Tackaberry, Director of Army Safety

# It Wasn't All the Driver's Fault

It began as a mission to tow a disabled 5-ton truck with a heavy expanded mobility tactical truck (HEMMT) wrecker, M984A1, to the unit maintenance collection point (UMCP). It ended with the driver having multiple skull fractures and severe brain damage and the passenger sustaining multiple head, back, and leg injuries. The cause of this accident was a chain of preventable human errors.

## Description of Events Immediately Preceding the Accident

The HEMMT wrecker, towing the 5-ton truck, was part of a convoy that was traveling 15 km over rolling terrain, marked with steep ridgelines reaching grades of over 10 percent. As the convoy proceeded down a long, sloping hill to a 'Y' in the road, the HEMMT wrecker veered to the left as the convoy lead proceeded to the right. The HEMMT wrecker honked his horn twice as if to signal a problem as his vehicle proceeded down the hill at an increasing rate of speed. It then careened off the road, went airborne for 34 feet, rolled to the right, and traveled an additional 150 feet before coming to rest upside down with the cab roof crushed.

As the accident investigation board began to pick through the facts surrounding this accident, it became obvious that unsafe soldier actions,

preconditions for unsafe soldier acts, supervisory failures, and an organizational failure had all caused this preventable accident to occur.

## Unsafe Soldier Actions

There were specific unsafe actions by the driver that directly contributed to the accident:

■ **Failure to follow procedure.** The driver failed to follow proper hook-up procedures as outlined in the operator's manual. The technical manual was present in the vehicle, but was not used.

The connection of these brake lines would have provided a means of deceleration by braking the back six wheels of the 5-ton truck.

■ **Speed violation.** The driver was traveling the route at speeds between 20-30 mph while following a commercial utility cargo vehicle (CUCV). According to the TM, the maximum speed for a HEMMT while maneuvering off-paved roads is 15 mph. At the point of departure from the road, the HEMMT and 5-ton truck were traveling approximately 36 mph.

■ **Driving blind.** The driver was unfamiliar with the road and the route. The dirt road was unmarked. Consequently, it was not until about 875 feet from the curve that the driver realized that the road did not continue straight, but in fact, made a sharp 115 degree right turn. But, at his rate of speed, it was too late to react and





maintain vehicle control.

■ **Driving skill error.** The driver elected not to use the 'Jacobs' engine brake for speed control. The Jacobs brake would have provided a means of deceleration by using the engine to slow the rate of speed. Additionally, the transfer case shift lever was in the HIGH position instead of the LOW position. The low position also would have provided an additional capability to decelerate the vehicle. This was felt to be the result of improper training.

### Preconditions for Unsafe Acts

While the unsafe acts by the driver were clearly the immediate causes for which this accident occurred, there were other equally important contributing causes. These causes were beyond the soldier's control, yet directly affected his performance. The soldier's unit could have avoided these problems.

■ **Fatigue.** The night prior to the accident, the driver's unit, a maintenance support team (MST), was only allowed 4 hours of sleep. They were awakened at 0300 for a movement ultimately delayed for 12 hours while the unit located some

missing equipment. These soldiers were not allowed to sleep. This clearly affected the accuracy and speed with which the driver could react in a difficult situation.

■ **Inexperience.** The driver and the co-driver were both inexperienced. The driver was a 63W10 (wheeled vehicle mechanic) and was licensed/qualified on the HEMMT only on level, paved roads. He was inexperienced in off-paved road driving, towing, or recovery of vehicles. The co-driver was a 45G10 (fire control systems repair specialist) and not qualified to drive the HEMTT. Their ability, individually or as a team, to risk manage the hazards of their mission that day were compromised.

■ **Support failure.** The Organizational Maintenance Shop (OMS) that conducted annual services on the HEMMT used the same preprinted checklist for all trucks regardless of the make or model. It shows a check for 'brake travel' which checks the travel of the brake pedal from full extension to where it stops on depression. This is fine for trucks with standard brakes, but it is not applicable to the HEMMT, which has air brakes. The proper procedure is to

## A Soldier's Failure May Not Be Due to His Own Actions



Adapted from Reason (1990)

Adapted from Wiegmann and Shappell (1998)

check for the slack adjustment on the HEMMT. As a result, the HEMMT wrecker had three of the four back brakes out of tolerance, rendering them ineffective. This situation did not cause the accident, but contributed to the inability of the driver to stop his vehicle soon enough to avoid the accident.

### Unsafe Supervision

Military organizations rely on the leadership of their supervisors (officer, noncommissioned officer, and civilian) to set the example and provide clear guidance for their soldiers to ensure mission success.

Circumstances in this accident cause one to question whether this happened:

■ **Failed to correct a known problem.** A battalion motor sergeant who observed the driver and co-driver hooking the 5-ton truck up to the HEMMT wrecker did not make an on-the-spot correction to let them know that they had forgotten to hook up the brake lines. He left to assist in repairing a Bradley. At the accident site, he specifically checked to see if they had attached the brake lines and noted that they had not. The power of on-the-spot corrections to stop problems from becoming accidents should never be underestimated.

■ **Inadequate NCO supervision.** The MST assistant section sergeant left with the UMCP serial instead of staying with the HEMMT wrecker convoy (the last group of vehicles). As the serial was about to depart, the sergeant instructed the CUCV driver (a PFC) to lead the last group to the UMCP when they were ready. There were no positive communication means established between vehicles, and the soldiers were not given a strip map or a route of march. Inexperienced leadership now complicated an inexperienced driver/co-driver situation.

■ **Inadequate maintenance supervision.** The OMS mechanic was not supervised or checked

by any production control or quality control supervisors during or after servicing the HEMMT wrecker. The failure to adjust the slack in the brakes may have been spotted at this time. This denied the driver effective braking when he most needed it.

### Organizational Failures

Army components have a responsibility to appropriately resource Army programs--to give the soldier the means to meet mission requirements. The Driver's Training Program is one such program that failed to set the stage so that this soldier could succeed in his mission.

■ **Driver's training program failure.** The driver's training program for this unit and most units of this major Army component was found to be deficient in that they did not provide ample training opportunities for the soldiers to become proficient in on-road and off-road driving conditions. To create circumstances where a driver must acquire his off-road skills during a deployment to an Army Training Center, while performing a support mission and without adequate train-up, should not be the way we do business.

### Conclusion

It is well recognized that human factors are involved in 80 percent of

all accidents. Unfortunately, when human errors, human failures, or human factors are mentioned, there is a tendency not to look beyond what the 'individual at the wheel' did, and simply allow the soldier to shoulder the complete responsibility for the accident. This HEMTT wrecker accident highlights the need to look beyond the soldier who was sitting behind the wheel. Failure to do so will result in a similar chain of human events repeating itself in the future...**with a more deadly outcome!!!** ♦

**Questions regarding this accident, contact MAJ Gary Kotouch, U.S. Army Safety Center, DSN 558-2933, [kotouchg@safety-emh1.army.mil](mailto:kotouchg@safety-emh1.army.mil)**

**We** SHOULD ALL BEAR ONE THING IN MIND WHEN WE TALK ABOUT A TROOP WHO 'RODE ONE IN.' HE CALLED UPON THE SUM OF ALL HIS KNOWLEDGE AND MADE A JUDGMENT. HE BELIEVED IN IT SO STRONGLY THAT HE KNOWINGLY BET HIS LIFE ON IT. THAT HE WAS MISTAKEN IN HIS JUDGMENT IS A TRAGEDY, NOT STUPIDITY. EVERY SUPERVISOR AND CONTEMPORARY WHO EVER SPOKE TO HIM HAD AN OPPORTUNITY TO INFLUENCE HIS JUDGMENT, SO A LITTLE BIT OF ALL OF US GOES IN WITH EVERY TROOP WHO IS INJURED OR DIES.

AUTHOR UNKNOWN



# Stop! Dismount Your Ground Guides, Soldier!

**T**actical operations put special demands on vehicle operators because of adverse environmental factors (rain, snow, mud, and dust), fatigue, and blackout operations as seen in the following accidents.

■ A company commander, preparing his unit for a National Training Center (NTC) rotation, gave a safety prebrief that included up-and-alert guards and the marking of sleeping areas with chem-lights.

Three days later, soldiers from a National Guard unit arrived and were assigned to augment his company for the approaching exercise. The following day, the platoon leader issued his operations order (OPORD) and added paragraph 6, *Safety*. He explained the marking and security level for the sleeping areas to include the track-dismounted soldiers' sleeping positions.

The unit deployed to the NTC, drew their vehicles, and began preparing for the exercise. Meanwhile, the track commander of a FISTV (M981 track vehicle) took his combat observation/lasing team (COLT) and established an observation point (OP) forward of a phase line. He conducted a map recon of the route he wanted to follow to the OP. He chose 0200 as the start point (SP) time for his mission.

At approximately 2030, the infantry company moved to their screen position for the upcoming operation. A team of five dismounted soldiers was assigned to the right flank of the platoon's position. They established and manned a

forward OP 20-30 meters to the right front of their Bradley Fighting Vehicle. At 2230, the order came to reduce the security level to 50 percent. For the dismounted soldiers, this meant that there would be half the soldiers awake and on security at all times.

At 0200 with zero percent illumination, the FISTV, followed by an NTC observer controller (OC), crossed their SP in blackout drive and traveled toward the phase line. The FISTV traveled for approximately 50 minutes when the driver and track commander observed chem-lights on the ground to their front. The track commander instructed the driver to drive to the right of the chem-lights.

Simultaneously, as the FISTV turned to avoid the chem-lights, the OC saw two soldiers jump up from the ground as the vehicle's track ran over one soldier. The FISTV continued on with the mission thinking they had avoided the area and did not realize that a soldier had been run over. The FISTV continued for approximately 30 minutes until an OC made it a safety kill and informed the track commander of the accident.

This accident is an example of soldiers failing to follow established procedures. The company commander didn't ensure that up-and-alert guards were posted around the assembly area. In addition, both the driver and track commander failed to stop the FISTV and dismount ground guides after identifying chem-lights.

*Army Regulation 385-55 states that tracked vehicle movement within or through an assembly area requires ground guides front and rear. Guides must be able to see each other and be visible to the driver.*

■ A 5-ton dump truck (M929) was being utilized to move training mines and barbed wire from the engineer supply point (ESP) to an area where an infantry company was preparing defensive positions. There was no unusual sense of urgency regarding the need to prepare the defensive positions. The platoon leader issued his order for the squad to lay a barbed wire obstacle and minefield forward of the defensive position. They began the mission



by cutting logs into 3-to 4-inch sections to be used as training mines.

At approximately 1800, the squad leader arrived at the ESP with his squad and the 5-ton dump truck. The squad leader conducted an area reconnaissance for emplacement of the barbed wire and mines and briefed the platoon leader on his emplacement plan. The platoon leader and engineer squad leader discussed where the barrier was to be placed and how the infantry unit would support them with personnel for the work party. The engineer squad leader noted the area where the infantry soldiers were

preparing their fighting positions. The work party began extending a wire obstacle that had been started earlier. At approximately 0215 after completing that portion of the barrier, the infantry platoon leader instructed his platoon to get some sleep, except those on guard.

With the wire obstacle completed, the engineer squad began laying the training mines. The squad leader directed that the 5-ton dump truck remain on the gravel tank trails when it moved between the ESP and minefield. That directive was to ensure the vehicle remained clear of the infantry fighting position to the rear of the barrier area.

The vehicle made two trips from the minefield to the ESP with no problems noted. Prior to the third trip to the ESP, the engineer squad leader determined that driver #1 was too tired to safely operate the vehicle and made a decision to replace him with the original ground guide. Since driver #1 was familiar with the designated route, he was designated as the ground guide for the vehicle.

The 5-ton dump truck proceeded to the ESP and picked up the third load of mines. They departed the ESP for the minefield at approximately 0245. After crossing a hardstand road, the ground guide stepped onto the driver side running board and rode on the vehicle for 75 to 100 meters. The ground guide instructed the driver to stop the vehicle so he could dismount and survey a shortcut into the

minefield. The ground guide moved approximately 30 meters into the field without observing any infantry positions. The ground guide directed the driver to follow him into the field, and began to lead the vehicle to where he believed was the start of the minefield.

After proceeding approximately 10 meters, the ground guide noted there were troops in the area and told the driver to be careful. The ground guide guided the vehicle between two infantry positions and made a left turn.

At that time, the engineer squad leader observed the vehicle moving through the area

where the infantry soldiers were located and yelled at the ground guide. The ground guide stopped the vehicle and moved to the rear of the vehicle to talk with his squad leader. The engineer squad leader informed the ground guide that they were approximately 100 meters from the minefield and were going in the wrong direction. He further directed the ground guide to move the vehicle to the right onto the gravel road

and to proceed to the minefield.

As the squad leader was returning to the minefield, the ground guide returned to the vehicle and climbed onto the driver side running board and instructed the driver to make a right turn. The ground guide remained on the driver side running board as the vehicle began to move to the right. After moving 10 to 15 meters, the ground guide began to dismount the vehicle. At the same time, the driver saw what he perceived to be a soldier attempting to crawl away from the front of the vehicle, and he stopped the vehicle. The ground guide also saw the soldier moving away from the vehicle, and approached the soldier to ensure he was not injured. The soldier told the ground guide that the vehicle had nearly run over him as he and his fighting companion slept to the rear of their two-man fighting position.

The ground guide looked under the vehicle and saw that the front left tire of the vehicle had run over the second soldier. Efforts to revive the injured soldier were stopped as the infantry

***Army Regulation 385-55 states that tracked vehicle movement within or through an assembly area requires ground guides front and rear. Guides must be able to see each other and be visible to the driver.***

platoon medic determined that the soldier was obviously dead.

The primary driver of the 5-ton dump truck, functioning as the ground guide for the vehicle during operations, made an improper decision. He deviated from his squad leader's instructions and rode on the running board instead of following correct ground guide procedures. The driver of the 5-ton dump truck did not properly use his ground guide during night operations. In addition, he allowed his ground guide to ride on the driver side running board rather than walk at the left front of the vehicle to ensure safety of personnel.

*Army Regulation 385-55 states that a vehicle operator must refuse to move a motor vehicle if anyone is in an unsafe position. (An unsafe position could be standing; attempting to ride between the cab and body; hanging on sides, running boards, or fenders; sitting on tailgates or sides of the truck; or extending arms or legs.)*

Commanders who are responsible for conducting tactical operations (actual or training) involving Army motor vehicles or Army combat vehicles and equipment

will apply all normal safety standards unless it is necessary to deviate to accomplish a mission. In training situations, such deviations may be authorized only by the unit commander. The commander will use the risk-management process and evaluate the significance of the assumed risk versus the training benefit. Drivers and ground guides must be trained in standard hand-and-arm signals and flashlight signals before driving or guiding a vehicle. They also must know the importance of a ground guide and ground guide duties.

A ground guide's purpose is more than just to walk in front of the vehicle. He is the control measure (safety measure) put in place in a hazardous or risky situation. Performing ground guide duties correctly can help reduce or eliminate those risks. It is better to dismount a ground guide and complete the mission safely than to complete the mission minus a fellow soldier.

**POC: SFC Erwin Bailey, Armor Safety Specialist, U.S. Army Safety Center, DSN 558-2908 (334-255-2908), [bailey@safety-emh1.army.mil](mailto:bailey@safety-emh1.army.mil)**

## New POV Video is Here

**N**ot the usual Army training film, this new video deals with the major causes of highway accidents in real-world terms. Soldiers will relate to the upbeat, entertaining manner in which the message is delivered. It should be widely available at local audiovisual libraries now. Check it out by asking for "The Road Show," PIN 711133 or visit our web site at <http://safety.army.mil> for ordering instructions as well as a downloadable facilitator's guide and additional briefing ideas. ♦

**POC: Ms. Rebecca Nolin, Media & Marketing Division, USASC, DSN 558-2073 (334-255-2073), [nolinr@safety-emh1.army.mil](mailto:nolinr@safety-emh1.army.mil)**



# THE ROADSHOW



# How Important is a Fire Extinguisher?

**R**hetorical question, huh? Well, let me answer it. Quite possibly it is the single most important piece of equipment to have in our vehicles. It's on the "before" operation PMCS checklist. Read on and I'll share a real-life scenario with you.

Earlier this year, an M923 5-ton overturned and caught fire. Trapped inside were two soldiers. These individuals were students in a driver training course on a night blackout drive mission. There were 33 vehicles (4 instructor vehicles) and not one had a fire extinguisher on board. Although there were other contributing factors in this accident, the bottom line is these individuals were fatally burned without anyone attempting to extinguish the fire because not one fire extinguisher was available.

How many times does an accident of this nature have to happen to get our attention? Fellow noncommissioned officers, ONE is too many, WAKE UP! We are essentially allowing troops to train in an unsafe environment and it has proven to be deadly.

These vehicles should not have been dispatched without the safety equipment present and operational. In accordance with TM 9-2320-272-10, Table 2-2 Operator/Crew PMCS, the vehicles were not "fully mission capable" if the fire extinguishers were missing or damaged.

Having worked as an emergency medical technician, I know the first thing that is done at the start of a new shift is to check the siren, emergency lights, IV fluids, etc., to ensure all are present and in working order before we put that vehicle in operation. If any life-saving device/equipment is missing, the vehicle is deadlined and we use the backup or have it fixed. It could cost a life if any of the equipment is missing or nonoperative. The emergency equipment for our military vehicles is just as important.

Fellow noncommissioned officers, it is up to us to make it a priority and ensure training is as safe as possible. In addition to ensuring all vehicles have a fire extinguisher, also ensure that everyone is trained on its proper operation.

**REMEMBER:** You are not only responsible for your actions, but also those you lead.

## LEAD BY EXAMPLE!

**POC: SFC Charlotte Underwood, Chemical Safety Specialist, Ground Systems Division, USASC, DSN 558-3530 (334-255-3530), [underwoc@safety-emh1.army.mil](mailto:underwoc@safety-emh1.army.mil)**



# New Safety Center Deputy Talks Risk Management

*Editor's note: Colonel John S. Warren became Deputy Commander/Chief of Staff of the U.S. Army Safety Center on 1 April 1998.*

I want the word to reach all soldiers that the Safety Center's philosophy is to protect the force through risk management. Risk management works. It is a proven, effective method of doing business. We must transition to a proactive approach to safety in which we truly take the risk-management process and integrate it into the Army culture and our way of life. It works in planning and executing military training and operations, and it works off-duty as well.

Risk management is a logic-based, common-sense process that will help commanders and other leaders make informed decisions on human, materiel, and environmental factors before, during, and after every operation. It is the leader's best tool for protecting the force.

While many 'old' warfighters associate risk management with the compliance-oriented safety 'inspection and rejection' policies of the past, the new warriors are finding that it has been simplified and is tailored into a user-friendlier tool. Safety professionals are now welcomed because they are not there in a compliance mode, but are truly there to assist in every way possible in the oversight of risk-management integration into all unit activities. Most importantly, risk management helps everyone accomplish their missions while saving lives and equipment.

The Safety Center can help commanders and other leaders with risk-management training. We provide risk-management publications such as *Countermeasure*, *Flightfax*, and *CAPP Report*; we have exportable safety course materials; e.g., CD-ROMs; and we produce videos that run the gamut of Army operations—aviation, ground, and civilian. We must change the way the Army thinks. That's a tall order. Is it worth it? If it saves a soldier's life, you bet it's worth it!

I agree with General Reimer when he said, "Risk management is not an add-on feature to the decision-making process, but rather a fully integrated element of planning and executing operations. ...Risk management helps us preserve combat power and retain the flexibility for bold and decisive action. Proper risk management is a combat multiplier that we can ill afford to squander."

Leaders have a responsibility to instill into the



hearts and minds of every soldier and civilian the basic principles of implementing the risk-management process. The first step is to integrate risk management into the planning, preparation, and execution of all operational missions. Secondly, make risk-management decisions at the appropriate level in the chain of command. And thirdly, accept no unnecessary risk. Leaders at all levels must decide whether to accept the level of residual risk to accomplish the mission.

I take my new duties very seriously and need your help. You are the safety experts and are in the organizations and positions where many of the Army's safety needs can best be identified. The Army must learn from past experiences if it is to avoid future accidental losses. Your ideas on how we can mutually support each other in the safety mission are always welcomed and encouraged. Working together as a unified team, we can all ensure that risk management is truly at the heart of our combined efforts by instituting programs to protect our soldiers, civilians, equipment, and installations from tragic accidents. ♦

—COL John S. Warren, USASC Deputy  
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# Safety of Use Messages

The following is a list of all safety of use messages (SOUMs) issued by Army Tank-Automotive Command (TACOM) for 2QFY98 and 3QFY98. Complete copies of all of the following messages are available from the Soldier's Support Network Internet website at [www-ssn.ria.army.mil](http://www-ssn.ria.army.mil)

■ **AMSTA-IM-O, 292036Z Jan 98, subject: SOUM, TACOM-WRN Control No. 98-02, crane, warehouse 10K.** Summary: Compliance with the instructions in this SOUM will close out TACOM-WRN SOUM 97-08 and take the subject cranes off deadline. SOUM provides instructions for inspecting the brake wheel cylinders and for properly bleeding the brakes. POC: James E. Jump, DSN 786-8901 (810-574-8901), [jumpj@cc.tacom.army.mil](mailto:jumpj@cc.tacom.army.mil)

■ **AMSTA-IM-O, 231513Z Feb 98, subject: SOUM, TACOM-WRN Control No. 98-03, Defective trailer air brake supply valve for the LMTV/MTV of the FMTVs.** Summary: TACOM-WRN has received reports that a defective trailer air supply valve causes rear wheel spring brakes (and trailer brakes if towing) to engage without warning. Users are directed to conduct a 100 percent inspection of all FMTV models listed in subject message to identify those vehicles produced with suspected trailer air supply valves. POC: Ronald Ford, DSN 786-7539 (810-574-7539), [fordr@cc.tacom.army.mil](mailto:fordr@cc.tacom.army.mil)

■ **AMSTA-IM-O, 031339Z Mar 98, subject: SOUM, TACOM-WRN Control No. 98-04, Deadline message for the HMT.** Summary: Due to a defect in the drawbar, users are directed to immediately prohibit the use of all HMTs identified in the subject message, including the AN/MJQ-35A and PU-801A, until further notice. This message does not apply to the three TQG PU-PP systems mounted on the HMT chassis trailers. In addition, maximum speeds on cross-country operations must not exceed 20 MPH. POC: Robert Dziewit, DSN 786-8656 (810-574-8656), [dziewitr@cc.tacom.army.mil](mailto:dziewitr@cc.tacom.army.mil)

■ **AMSTA-IM-O, 10145Z Mar 98, subject: SOUM, TACOM-WRN Control No. 98-05, Technical, Possible defective driveline U-joint driveshafts used on the FMTVs.** Summary: Users are directed to conduct an immediate 100 percent inspection of all LMTV cargo vehicles listed in subject message to identify those vehicles with suspect rear driveshafts. Effective immediately, a maximum driving speed of 30 MPH is imposed until further notice. This SOUM provides inspection criteria, reporting

procedures, and contractor points of contact. POC: Ronald Ford, DSN 786-7539 (810-574-7539), [fordr@cc.tacom.army.mil](mailto:fordr@cc.tacom.army.mil)

■ **AMSTA-IM-O, 191131Z Mar 98, subject: SOUM, TACOM-WRN Control No. 98-06, Deadline the HMT.** Summary: This message clarifies the deadlining criteria and model information provided in TACOM-WRN SOUM Control No. 98-04. POC: Robert Dziewit, DSN 786-8656 (810-574-8656), [dziewitr@cc.tacom.army.mil](mailto:dziewitr@cc.tacom.army.mil)

■ **AMSTA-IM-O, 171743Z Jun 98, subject: SOUM, TACOM-WRN Control No. 98-07, Operational, Safe operating speeds for the M939 family of vehicles.** Summary: This SOUM reiterates maximum safe operating speeds and braking procedures and also provides additional warnings and safety information that must be inserted into the appropriate technical manuals. POC: Katie Gorski, DSN 786-8647 (810-574-8647), [gorskik@cc.tacom.army.mil](mailto:gorskik@cc.tacom.army.mil)

■ **AMSTA-IM-O, 271203Z Apr 98, subject: SOUM, TACOM-WRN Control No. 98-08, Technical, Update to TACOM-WRN SOUM Control No. 98-05, DTG 101451Z Mar 98.** Potential catastrophic driveline failure on driveshafts used on the FMTVs. Summary: This message is an update on TACOM's effort to determine the cause and solution to prevent further driveshaft/drivetrain failures and provides additional guidance and inspection procedures. The 30-MPH speed limit restriction on all 2½ ton LMTV cargoes remains in effect. POC: Ronald Ford, DSN 786-7539 (810-574-7539), [fordr@cc.tacom.army.mil](mailto:fordr@cc.tacom.army.mil)

■ **AMSTA-IM-O, 271216Z May 98, subject: SOUM, TACOM-WRN Control No. 98-09, Technical, Potential catastrophic driveline failure on driveshafts used on the FMTVs.** Summary: A thorough study of the 2½ ton LMTV has indicated that the 5-ton exhibits the same powerpack bending that has caused catastrophic failures of the driveline in the 2½ ton LMTV. Thus, the potential for the failure exists in the 5-ton as well. SOUM requires users to conduct a 100 percent inspection of all MTV vehicles listed

in the subject message. A maximum speed restriction of 30 MPH is imposed on all 5-ton MTV vehicles. POC: Ronald Ford, DSN 786-7539 (810-574-7539), fordr@cc.tacom.army.mil

■ **AMSTA-IM-O, 021217Z Jun 98, subject: SOUM, TACOM-WRN Control No. 98-10, Technical, Retread non-directional cross-country (NDCC) bias-ply tire used on various vehicles.** Summary: Recent testing for the national retread program and field reports have shown that subject retread NDCC bias-ply tires experience a high rate of failure. This SOUM requires users to inspect all vehicles within 5 days of receipt of this message, remove all retread NDCC bias-ply tires from steering axles and single wheel non-steering axles within 30

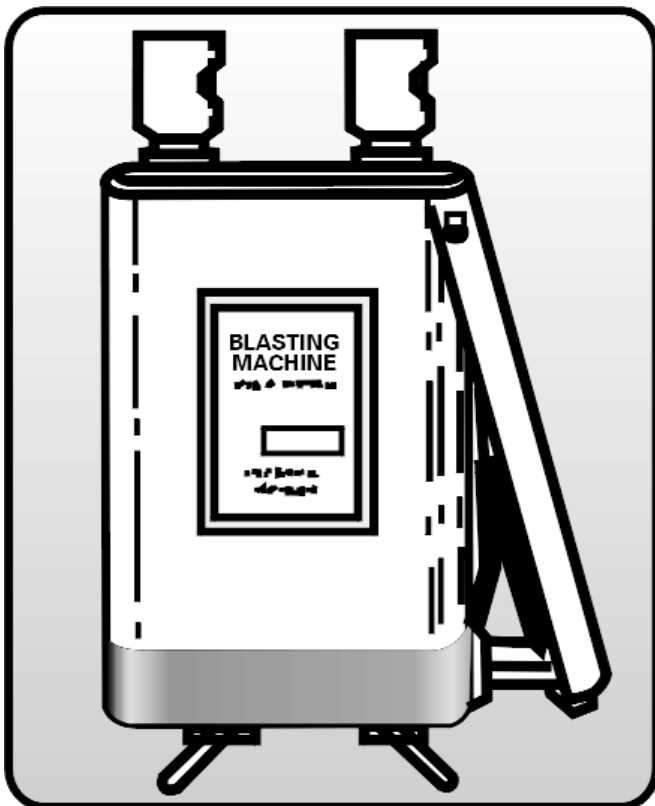
days and replace them with non-retread tires or the vehicle is considered non-mission capable. POC: Ralph E. Eldridge, DSN 786-8379 (810-574-8379), eldridge@cc.tacom.army.mil

■ **AMSTA-IM-O, 171743Z Jun 98, subject: SOUM, TACOM-WRN Control No. 98-11, Operational, Vessel affected: NDI large tug, 128'.** Summary: The current configuration of the Army large tug has been identified as having several design-related problems, all of which may have an adverse systemic effect on vessel stability. SOUM provides references, procedures, and guidance to maximize the stability and safe operation of the vessel. POC: Steve Dull Jr., DSN 786-8512 (810-574-8512), dulls@cc.tacom.army.mil ♦

# Urgent Safety Message

## M34 Blasting Machine

**D**eadline M34 Blasting Machine. TACOM-ACALA Rock Island, IL, AMSTA-AC-SF, 231846Z Jul 98, SOUM 98-05. This SOUM deadlines M34 Blasting Machines manufactured by Minowitz Manufacturing and all M34s for which the manufacturer cannot be identified. The M34



Blasting Machine, NSN 1375-00-567-0223, has demonstrated a safety problem.

A measurable voltage is released to the terminals when:

- The bail lock is released to allow the handle of the blasting machine to extend to the ready position.

- The handle is squeezed one time. This voltage is sufficient to detonate a blasting cap if it is connected to the machine when deployed.

Minowitz M34 Blasting Machines are identified by a lot number either etched or stamped on the bottom of the machine beginning with MMW. If you have a Minowitz Blasting Machine or a blasting machine that cannot be identified as manufactured by a company other than Minowitz, it must be removed from service until the machine can be tested. A detailed test procedure will be issued in a follow-up message when available.

There are in excess of 8000 blasting machines fielded that could fall into this category. This item is not separately issued, but is a component of two supply catalogs, SC 1375-95-A03, demolition kit (LIN F91490, NSN 1375-00-047-3150) and SC 1385-95-A03, EOD field maintenance set (LIN T57126, NSN 1385-01-095-5221), and used with mine clearing line charge (MICLIC, LIN L67342). ♦

**POCs: Doug Heritage, DSN 793-1709, heritag@d@ria.army.mil or Don Wren, U.S. Army Safety Center, DSN 558-1122 (334-255-1122), wrend@safety-emh1.army.mil**