FY20 FATALITIES as of 20 August 2020	Aviation	Ground On-Duty	Car	Motorcycle	Other	TOTAL
	0	16	12	6	10	44

www.safety.marines.mil *Numbers in fatality categories are subject to change based on final disposition of investigation.* Vol. 20 - Ed. 4

COMBATTING THE BLUE THREAT

"As good as we are today, we will need to be even better tomorrow to maintain our warfighting overmatch"

General David H. Berger, U.S. Marine Corps.
Commandant of the Marine Corps

Inside This Edition

From the Director...

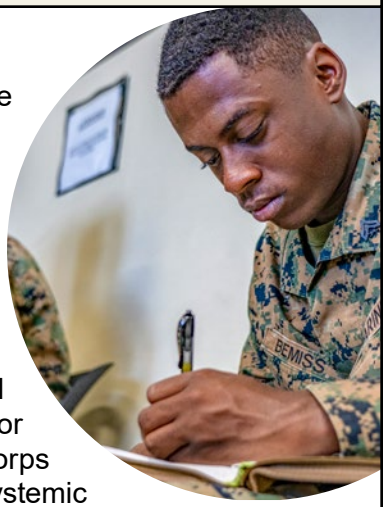
Make the Right Choice

After you squeezed the trigger on the nail gun and realize you have just secured your hand to the roof, along with the shingle you were attempting to affix, your next thought was probably "I knew that was going to happen." You have just relearned the don't rush lesson. This issue of the Blue Threat goes one step further in breaking the mishap chain. Your buddy, a fellow Marine, is shingling his house next week. Test question: Should you tell him what happened? Even better, should you fill out a HAZREP or mishap report and tell all Marines what happened? Test answer: Yes! Do we do this? No! Marines, we are making the same mistakes over and over, in large part because we aren't reporting our mistakes and our near misses. This is a choice. We need to choose to report, and we need to encourage and reward Marines for reporting.

Semper Fidelis,

Col Marty "Trainwreck" Bedell
Director, CMC Safety Division

Reporting Culture



The Commandant's Planning Guidance (CPG) makes it clear: "As good as we are today, we will need to be even better tomorrow to maintain our warfighting overmatch." Improvement doesn't happen overnight, and it requires forethought and intention. Positive change requires honest and accurate assessment of your command—not only in the Status of Resources and Training System (SORTS) and Defense Readiness Reporting System (DRRS) reports, but also in the quality of information passing between your leaders and subordinates throughout the chain of command.

We can't foster improvement if we can't see ourselves clearly and in detail. The consistent reporting of mishaps, near misses, and hazards provides leaders with the level of detail needed to make informed decisions. We all have personnel shortages and training or materiel issues that can lead to near misses and mishaps. When the entire Marine Corps reports, we can learn from each other's data. We can recognize specific as well as systemic issues, and we can respond with the necessary manning, training, or equipment to minimize risk and improve operational readiness.

Continued on page 3.

DID YOU KNOW? Most mishaps contain causal factors identified in previous mishap investigations.

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Recent Class A Mishaps

- **AVIATION**

  NONE

- **GROUND ON-DUTY**

  14 Aug 2020: Orlando, FL – Poolee participated in DEP physical training event, fell and struck head and subsequently appeared dazed, and transported by ambulance to local Emergency Room Medical professionals declared poolee deceased at the hospital..

  31 Jul 2020: Macon, GA – A Marine was declared deceased due to an accidental drowning that occurred during a training exercise.

  30 Jul 2020: San Clemente Island, CA – During recovery, an AAV began taking on water and rapidly sank with 16 passengers and crew onboard. Eight Marines and one Sailor were declared deceased.

- **OFF-DUTY (CAR)**

  13 Aug 2020: Havelock, NC – While on liberty, two Marines were involved in an automobile accident. The driver was not wearing a seatbelt and was pronounced deceased at the scene.

  01 Aug 2020: Kaneohe Bay, HI – While traveling on the Likelike Highway, a vehicle struck a wall in the vicinity of the Wilson Tunnel. Two Marines were deceased.

- **OFF-DUTY (MOTORCYCLE)**

  01 Aug 2020: Philadelphia, PA – Cpl died after head on collision with a motor vehicle while riding a motorcycle.

- **OFF-DUTY (OTHER)**

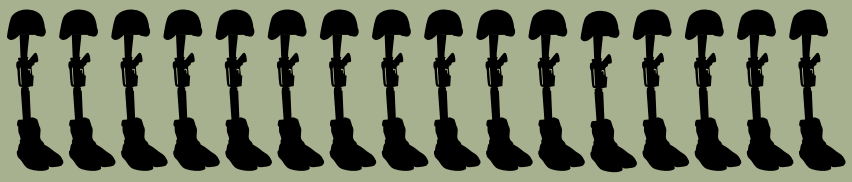
  16 Aug 2020: Yuma, AZ – A Marine was fatally wounded in an ATV rollover accident.

  02 Jul 2020: Hamada, Japan – A Marine drowned while trying to assist others in a rip current.

FY20 Class A Mishaps

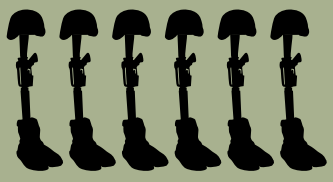
8 GROUND MISHAPS

resulted in the death of fifteen Marines and one Sailor



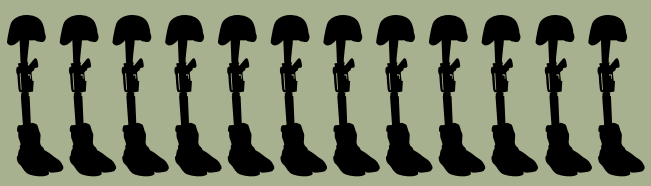
6 MOTORCYCLE MISHAPS

resulted in the death of six Marines



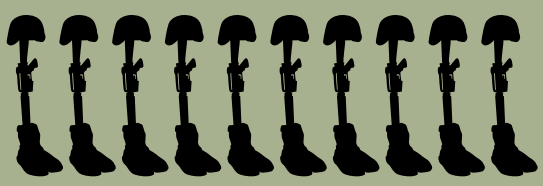
10 CAR MISHAPS

resulted in the death of twelve Marines



10 OTHER MISHAPS

resulted in the death of ten Marines



Commanders Lead the Change. Active reporting of hazards allows us to assess the risks associated with those hazards, which in turn allows us the opportunity to implement controls. We have then set the conditions for accomplishing our missions, strengthening our forces, and making sure we have all our Marines ready when we most need them. Improving our reporting culture requires the buy-in and active participation of our Commanders. They need to consider whether the message they convey to their subordinates promotes reporting as part of a just culture within their unit. Are there incentives for reporting hazards, near misses, and mishaps, or is reporting treated (even inadvertently) as a negative that draws unwanted attention? If Commanders at all levels believe and make known that reporting is important, then their units will also consider it important.

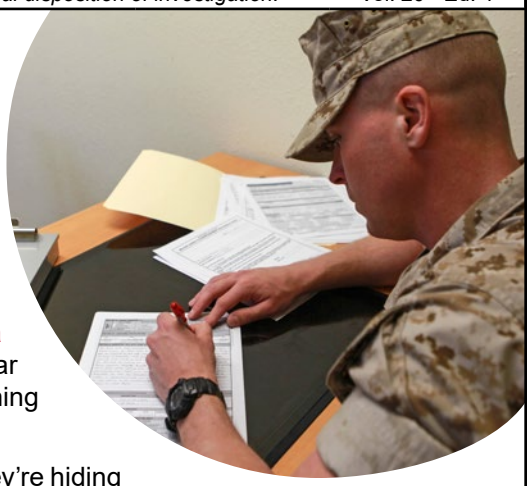
Why Reporting the Small Stuff Matters

Commanders can only lead change well with a clear and comprehensive understanding of our current situation—and that requires the attention and input of every Marine. Operational excellence requires more than top-down directives; **it is the shared ownership of outcomes, both good and bad**, **by all members of a unit,** and those outcomes are largely determined by the contributions of its participants. Consistent reporting acts as both eyes and ears for your leaders, Marines. Even the small stuff matters.

While the Class A and B mishaps get the most attention, Class C, D, and E mishaps provide invaluable insight into looming Class A mishaps. The unsafe act or condition that leads to the Class A can usually be observed in the less severe incidents, so if you take the time to thoroughly investigate the seemingly minor and insignificant mishaps and implement actions to prevent them, you prevent the Class A mishaps from occurring by addressing known hazards before they strike.

Hazards, causes, and contributing circumstances are all lost when not reported. When mishaps and near misses are not reported, their causes usually go uncorrected. That means they are likely to happen again, causing tomorrow's disabling injury or fatality. Reporting provides a way to monitor potential problems and root causes as they recur. Documenting these problems and root causes allows repeated failures to be noticed and corrected before they result in a mishap.

Why Don't You Report Your Misfires, Your Engine Stalls, Your Over-Speeds, Your Flame Outs, Your OBOGS Failures?



It didn't even occur to me that I should report it.

Let's say you had a close call. Why report it when nothing actually ended up happening, right? The thing is, if you caught something just in time, or corrected an issue before it really became a problem—that's a near miss. **Every "almost" has the same causes and contributing factors as a mishap**, and understanding the causes and factors surrounding the near miss helps keep the seemingly insignificant from blowing up into something serious.

Then again, sometimes we overlook situations worth reporting because they're hiding in plain sight. Regardless of whether it's a potential hazard or cutting a few corners in a procedure, people stop really noticing something when they see it all the time. Just because an action or event is so commonplace that it's unremarkable doesn't mean that it's not worthy of reporting. That's called the "normalization of deviance," and it contributes to most mishaps.

I don't know how or where to make a report.

- Each unit has a Unit Safety Officer (USO) that can assist with open reporting based on the situation.
- Alternatively, you can also drop a note in your unit's ANYMOUSE box. Every unit is directed to establish, maintain, and monitor an anonymous reporting and feedback system (called "ANYMOUSE") to identify unsafe or unhealthful working conditions. The "ANYMOUSE" program requires "ANYMOUSE" forms and a receptacle placed in a discreet area allowing easy access for all personnel. The safety officer is responsible for checking the box regularly and immediately bringing all safety concerns to the commanding officer.
- All flying squadrons and aviation ground units in the Marine Corps have the option in the Aviation Safety Awareness Program (ASAP) to utilize the ASAP's ANYMOUSE functionality. Each squadron has a generic ANYMOUSE login—a username and password provided to every member of the unit. The user can log in using their cell phone, so a lack of squadron computers or CAC access are not barriers to use.

It will make my unit look bad.

Most people don't like to call themselves out on the mistakes they or their unit have made (or almost made); it's like shining a big spotlight on something you don't want anyone to see. That said, it's still incredibly valuable information to report. Even minor mistakes and near misses can provide insight about potential hazards or risk calculations not only at the individual level but also affecting overall unit safety.

It's embarrassing.

If you're waffling on whether to report because it's a little embarrassing, understand that's why ASAP and ANYMOUSE reporting exist—because what's most important about reporting is that the event happened, not that it happened to you, specifically. Mistakes happen. Report it anonymously, share it with your team, a Ready Room confessional, or any other forum you choose—but most importantly share it, report it!

It's not worth going through the hassle of reporting.

We all need to learn from each other's experiences. Near misses and hazards, even minor mishaps, might seem like more trouble than their worth to report, but you can't gauge how much it might influence your supervisors, and you can't guess which of your fellow Marines would benefit most from you sharing it. Every near miss exists only inches and seconds from a tragedy. There's a lesson in every small thing.

Streamlined Incident Reporting (SIR) is Coming to the Marine Corps

The Risk Management Information (RMI) initiative is a mission-essential capability to improve the readiness of the Department of the Navy (DON) in the areas of safety data capture, data management, data analysis, and the dissemination of leading indicators of safety risk to our Sailors and Marines.

RMI consists of four capability areas, or pillars:

Streamlined Incident Reporting (SIR) will provide enterprise enhancements to include streamlined reporting processes; improved unit reporting access and capabilities; and enterprise and unit level tracking and verification of reportable medical injuries.

Safety Program Management (SPM) will provide users with capabilities needed for planning, preparing and executing a safety and occupational health program. Specific capabilities include: confined space entry, deficiency abatement, fall protection, inspections, job hazard analysis, medical surveillance, respiratory protection, safety committee, self-assessment and training.

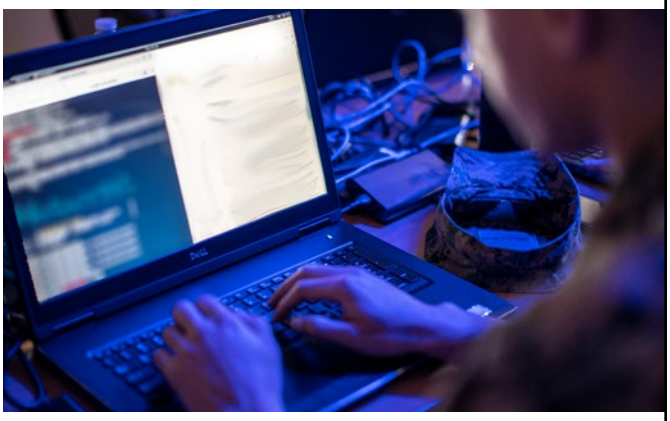
Analysis and Dissemination (A&D) will provide an advanced analysis and analytic capability for SIR and SPM data that will enable trend analysis and proactive decision making related to mishap and injury avoidance in compliance with the Department of Defense (DOD) Safety and Occupational Health standards and policy.

Single Point of Entry (SPOE) will provide a single point of entry available to Sailors, Marines and safety professionals to reduce the inconsistencies introduced by dissimilar legacy systems and organizations.

As part of the RMI initiative, the USMC will be transitioning into a new reporting system called Streamlined Incident Reporting (SIR). RMI SIR is a web-enabled, role-based mishap reporting and analysis system accessible worldwide with a Common Access Card (CAC). RMI SIR is a single integrated mishap system for reporting aviation, afloat ground and motor vehicle mishaps compliant with Department of Defense (DOD) safety business rules. Using RMI SIR will vastly expand the capabilities for safety professionals and leadership to identify trends and produce analyses that lead to recommendations and mishap prevention.

RMI's SIR provides a baseline of Class C and D mishap incidents, hazard reports (HAZREPS), and near misses, and will provide the basis for analysis and trending for all classes and types of incidents to improve safety and risk management. RMI will also enable increased safety reporting efficiency by reducing the amount of time users spend entering or reentering safety data into the system.

Memorandum of Final Evaluation (Replaces WESS Concur/Non-Concur Endorsement Process)

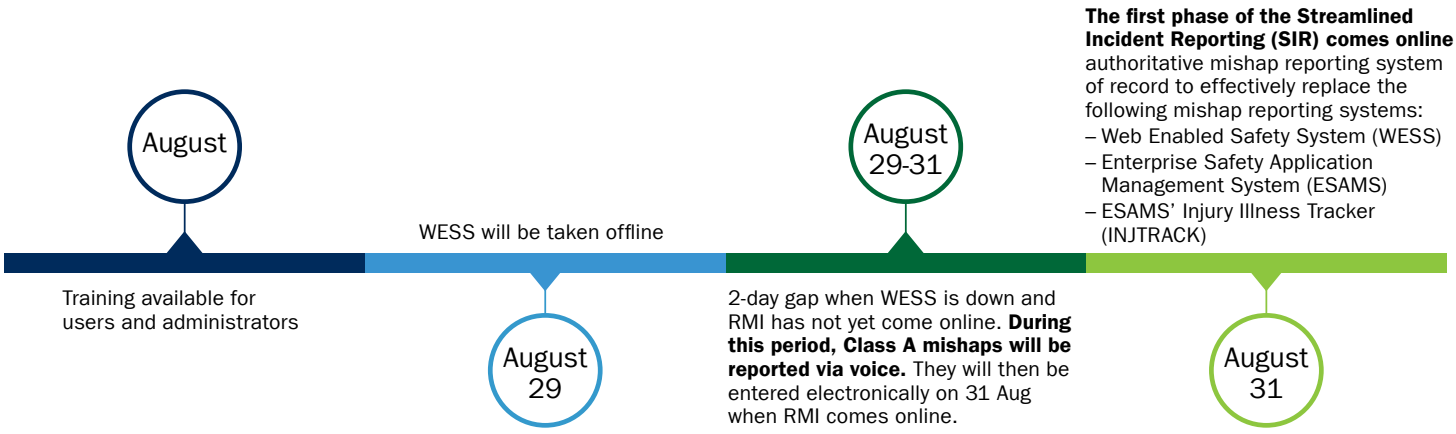


The Memorandum of Final Evaluation (MOFE) is the DoD process used to report and comment on findings and recommendations resulting from Class A, B or select C events. The MOFE does not replace the SIB's final message but ensures quality control standards, actionable recommendations, and compliance standards are maintained to identify hazards and support future event prevention efforts.

Key Points

- MOFE comments are submitted in parallel of each other, which differs from WESS endorsements that were submitted in a serial fashion.
- The MOFE process ensures quality control standards are applied, actionable recommendations are reviewed and compliance standards are maintained in support of future mishap prevention efforts.
- The MOFE process spans a 90-day timeframe: the first 45-day period is for organizations to submit solicited and unsolicited comments regarding the final outcome of the mishap investigation and the second 45-day period is for the Naval Safety Center to collate all comments and release a final message.
- All MOFE comments must be received by the 45-day deadline.
- The 45-day MOFE timeframe for comments enables an efficient channel to quickly provide safety recommendations that are value added to the fleet, in contrast to the legacy WESS endorsement process which suffered from extended and often delayed endorsement timelines, which translated unmitigated risk to the fleet.

2020 Timeline of Events



RMI SIR Familiarization Training Schedule

In preparation for the Aug. 31 launch of RMI SIR, NAVSAFECEN now provides virtual SIR familiarization training through Aug. 27 with more than 40 scheduled online sessions. Instructional training will include account access, accounts management, entering mishaps and recommendations, memorandum of final evaluation (MOFE) endorsements, basic analytics and running reports.

The eight-hour live sessions scheduled from 8 a.m. to 4:30 p.m. will start promptly within each respective time zone. All training sessions will be recorded and RMI SIR users can reference these in the future. All safety professionals, safety specialists and collateral duty safety officers are strongly encouraged to attend.

Students will access training as portrayed below for their respective time zones. Students will log in as a guest and can listen to the lecture with speakers or headphones.

RMI SIR Familiarization Training Schedule

Date	Weekday	Time Zone	Training Link
Aug 24	Monday	CHST	http://navsafetc.adobeconnect.com/rmi
Aug 24	Monday	JST	http://navsafetc.adobeconnect.com/rmi2
Aug 25	Tuesday	AST	http://navsafetc.adobeconnect.com/rmi3
Aug 25	Tuesday	CET	http://navsafetc.adobeconnect.com/rmi
Aug 26	Wednesday	CET	http://navsafetc.adobeconnect.com/rmi
Aug 26	Wednesday	EST	http://navsafetc.adobeconnect.com/rmi2
Aug 27	Thursday	HST	http://navsafetc.adobeconnect.com/rmi
Aug 27	Thursday	PST	http://navsafetc.adobeconnect

EST	Eastern Standard Time	CET	Central European Time (Italy, Spain)
JST	Japan Standard Time	AST	Asian Standard Time (Bahrain)
CST	Central Standard Time	CHST	Chamorro Standard Time (Guam)
HST	Hawaii Standard Time		

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Have You Used the ASAP MISHAP Tracker Yet?

This tool was designed to make **Aviation MISHAP** data easy to access, search, and display in formats that can help identify adverse trends and facilitate the development of corrective action for systemic issues. This search ability also helps to identify legacy and predictive organizational and human performance threats and errors allowing for more proactive risk management using ASAP's real-time data collection capabilities.

If you have a personal ASAP account for your unit, you have access to the search tool. To use the ASAP MISHAP search engine, go to the USMC ASAP site, select 'MISHAPS', 'MISHAP SEARCH'. This will bring up the Search Specifications page where you will see all of the iterations and combinations available for you to research MISHAPS. Once your selections have been made, you have several options on how you want your information to be displayed, including exporting it to an Excel spreadsheet.

Let's say you choose to export your search request to Excel. In just a few minutes, you can select the information you wish displayed and create the exact spreadsheet you want. The information populating the spreadsheet is now totally accessible. For example, let's say you're the ASO for an RQ-21A squadron and you want to take a quick look at your Mishaps in FY19. In this case, you selected the information across the top on the Excel page, and your inquiry produced a spreadsheet. (Note: you also get the additional spreadsheet breakouts shown at the bottom of the page like Class A's, Class B's, etc.).