NAVAL SAFETY COMMAND
SAFETY AWARENESS DISPATCH
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The Consequences of Not Speaking Up

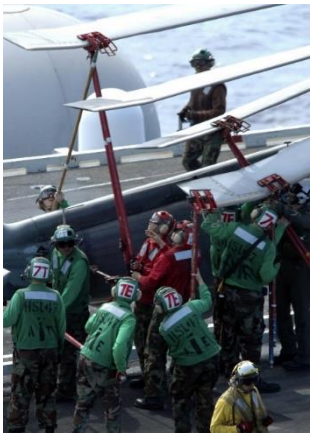
"***Be a voice, not an echo***" — Albert Einstein

Have you ever had a gut feeling that something wasn't right about a procedure or evolution, but you didn't say anything at the time? Or how about not feeling well, but you didn't speak up? Well, you're not alone. We've all likely been in situations where, in hindsight, we knew we should've said something sooner. In this dispatch, we spotlight a few examples from our database (*there are many*) where service members held onto info that would have been helpful before a mishap and may have prevented an incident altogether. Read and learn how our "keepers of secrets" contributed to avoidable incidents.

- Well, There Goes Our Produce for the Week. During a ship's underway replenishment, a pallet began swinging excessively and struck the receiving ship's lifeline stanchion and the sliding padeye. Portions of the load fell over the side, on the ship's deck and struck a Sailor on his right leg. The Sailor was taken to medical with contusions to his leg. This ship had a near miss the previous week in a similar incident. A common factor during both events was a lack of communication. Many on the receiving ship's crew believed the cargo loads were coming over too fast but didn't stop the transfer and communicate their concern with the supply ship. After some earlier loads had swung violently and hit the DDG's deck edge, personnel on both ships' stations and bridges should have communicated their concern. — *This example was a classic "if you see something, say something" moment where multiple personnel had opportunities to break the error chain, but it wasn't until someone got hurt and stores went into the ocean that the unsafe evolution stopped. If you know it isn't right, speak up. And leaders, empower your teams to do so.*

- Wakeup Call. Three Marines were returning from a night out in town when the driver fell asleep, causing the vehicle to collide with the center barrier and rollover multiple times. All three Marines were wearing seatbelts and were treated and released from the hospital—*and were fortunate to be alive!* Kudos to the Marines for having a non-drinking designated driver, but they earned a zero for execution because the driver was awake for nearly 23 hours before the accident. While he had seven hours of sleep the night before, he awoke at 0350 to pick up his fellow Marines to report to work. They were on their way home from the night out at 0240 the next day when the incident occurred. The driver also recalled falling asleep several times and awoke again when the car slammed into the center barrier. —*Most of us have had training where we learned that fatigued driving from lack of sleep can have the same effect as consuming alcohol. "Pushing through" when you know you're falling asleep at the wheel is asking for disaster. Speak up and get off the road. Even if your friends are asleep, they'd rather be woken up than dead.*

- Give me a Break. Three maintainers, M1, M2 and M3, were tasked to load sonobuoys onto an aircraft. They used a pickup truck and a trailer to move the sonobuoys from the hangar to the aircraft because there was no proper buoy truck at the squadron. After backing the trailer up to the hangar loading dock, M1 set the parking brake, turned off the truck and exited to assist M2 and M3. The truck then began rolling toward the aircraft. M1 ran to stop the truck but didn't reach it in time. The truck collided with the aircraft's weapons bay door, scratching the weapons bay and cracking the truck's windshield. Unknown to the driver, some maintainers at the squadron knew the truck's parking brake was failing but didn't tell anyone. Adding to the misery, the lack of a buoy truck at the squadron was a long-standing issue that for years received no solution. —*While the Sailors used ingenuity to get the job done, we owe it to them to supply them with the right equipment. But if they don't speak up, we can't help. We don't know how far up*



the chain of command this issue was known, but we know nothing was done about it. Naval Safety Command's assessment process aims to ensure commands hold risk ownership and accountability at the appropriate level and hazards are promptly communicated up and down the chain of command. Please help us help you by speaking up and reporting hazards up the chain.

• Open and Shut Case. After traversing a helicopter from the ship's hangar, a maintenance crew began the blade spread evolution. Maintainer 1 (M1) climbed on top of the aircraft with the required blade fold test set to spread the blades. M1 did not, however, bring a Portable Electronic Maintenance Aid (PEMA) to reference and attempted the procedure by memory. Upon the arrival of the required personnel (minimum of five), M1 began to manually spread the rotor blades. While doing it from memory, he confused the spreading and folding steps and began the folding procedure. By doing it wrong (*with at least four other maintainers present*), M1 inadvertently caused the retraction of the pitch lock pins on the blue blade without realizing he was following (*in his head*) the wrong procedure. Then, he continued by doing the same wrong steps for the red blade. With the lock pins out, the red and the blue blades both dropped from the folded position, causing the blue blade to impact the #2 exhaust. In their efforts to fix everything, eventually the team punctured the blue blade. *—In the "failed to effectively communicate" category, Maintainers 2 through 5 knew M1 needed to use the PEMA for reference during the evolution, but no one spoke up. This expensive incident wouldn't have happened if someone only said, "Hey, where's the PEMA?"*

• Not a Big *Fan*. A group of maintenance Sailors was performing corrective maintenance on an auxiliary machinery room supply ventilation fan. Frustrated with the difficult location of the fan and knowing the repair was unsafe and unauthorized, the Sailors cut an access hole in the ventilation tubing to save time. The power was secured, but the fan was still spinning freely due to the pressure differential in the space. During the work, a Sailor lost his balance and tried to recover, but his left hand contacted the exposed fan blades, which de-gloved his third and fourth fingers *("degloved" is a gentle word for* "*ripped off all the layers of his skin and connective tissues, like a glove being ripped off*). The report noted the division had a "just get it done" culture and, after the work was identified as unsafe, maintenance continued without senior leadership present to ensure safety and provide forceful backup. *—This mishap is a classic case of organizational drift, where cutting corners became the norm and inevitably, someone got hurt. No one spoke up about the dangerous procedure because they either were in "get it done" mode or felt it wouldn't be well-received by leadership. Leaders, ensure your team's safety by following procedures, being present and cultivating an environment where people know they can speak up.*

Key Takeaways

In each mishap in this dispatch, someone had a piece of information that, if shared, would have averted the accident. In some cases, they decided not to say something, and in others, they may not have felt empowered to speak up. These takeaways should be obvious:

1. **Silence kills (*or sometimes rips all the skin off your hand*)**. Speaking up when something doesn't feel right can prevent costly mishaps. We've said it before, "You don't want to be the one caught holding a secret." All too often, mishaps result from someone having a critical piece of information and either feeling that they aren't empowered to speak up or assuming everyone else knows the information already. Leadership should encourage open communication at all levels.

2. **Get real about your unit's culture**. Building on takeaway #1, whether you're a commanding officer, division head, squad leader, etc., you have a crucial role in supporting a culture of operational excellence (and, therefore, safety) in whatever capacity you serve. An essential element of a healthy organizational culture is genuinely empowering people at all levels to speak up. The CNO's call to "Get Real, Get Better" isn't a slogan; it's a mindset of self-assessing, self-correcting and always learning. And that mindset starts with speaking up, or again, "If you see (or feel) something, say something."

And remember, "Let's be careful out there"