DEPARTMENT OF THE ARMY
UNITED STATES ARMY INTELLIGENCE CENTER AND FORT HUACHUCA
1903 HATFIELD STREET
FORT HUACHUCA ARIZONA 85613-7000

REPLY TO
ATTENTION OF

ATZS-CG

29 April 2005

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: POLICY 140 – Fatal Accident Notification Fatality Review Board

1. REFERENCES.

a. AR 385-40, Accident Reporting and Records, 1 Nov 94.

b. Change 1, 10 Oct 00, to TRADOC Reg 385-2, TRADOC Safety Program, 27 Jan 00.

c. TRADOC Reg 1-8, TRADOC Operations Reporting, 13 Nov 01.

d. Memorandum, HQ TRADOC, ATCS-S, 23 Dec 03, sab.

2. POLICY. In addition to notification and reporting procedures outlined in references 1a-c above, the memorandum referenced at 1d establishes TRADOC policy and specific procedures for notification, investigation, and reporting on the accidental death of any TRADOC Soldier. In accordance with this policy, the procedures outlined below are implemented within the US Army Intelligence Center and Fort Huachuca (USAIC&FH), effective immediately.

3. PROCEDURES. In the event of a death of a Soldier or Department of the Army civilian assigned to USAIC&FH, as a result of an accident, the following procedures will be followed.

a. The unit commander of the accident victim will provide the facts and circumstances surrounding the incident to the USAIC&FH Safety Manager within 24 hours.

b. A Fatality Review Board (FRB) chaired by the Deputy Commander or the Chief of Staff will be established to review each fatal accident. The FRB will be convened within 14 days of the incident.

c. The purpose of the FRB will be to ensure that fatal incidents are investigated in a timely manner, to identify causes or contributing factors and determine necessary leader actions to prevent recurrences.

d. To provide a multidisciplinary approach to review the causes of Soldier and civilian fatalities, the FRB will be comprised, at a minimum, of the following members:

(1) Unit/organization chain of command/supervision from first line supervisor to brigade commander or equivalent.

(2) Fort Huachuca Safety Manager.

(3) MEDDAC Commander or Deputy Commander for Clinical Services.

(4) Other members as required or directed (e.g. Alcohol and Drug Counseling Officer, Provost Marshal, Chaplain, Casualty Affairs Officer, Chief Mental Health Services, and investigating officers.)

e. The FRB AAR will address, at a minimum, personal data on the victim or involved individuals, pre-accident phase (chronological sequence of events occurring within 48 hours prior to the incident), synopsis of the event, causative and contributing factors, maps and diagrams, and other documentation as appropriate, related risk assessments and risk management plans and assessment of the unit's safety and accident prevention programs and initiatives, and corrective actions and recommendations. Commanders will determine if leader's actions, at all echelons, could have prevented the accident. A sample AAR format is provided at Enclosure 1.

f. The results of the FRB will be forwarded to the USAIC&FH Commanding General upon completion of the assessment. The assessment will focus on the cause of the accident and any contributing factors (including any leadership failures) corrective actions taken, and any recommendations to prevent recurrence.

3. PROPONENT. Fort Huachuca Safety Manager, 533-3697.

Encl
as

BARBARA G. FAST
Major General, USA
Commanding

DISTRIBUTION: E

Unit Name
Fatal Accident
After Action Review
For
Name(s)

Date of AAR_____

Figure 1

Fatal Accident AAR Briefing Agenda

- Biography/Personal Data
- 48-Hour Sequence of Events
- Accident Synopsis
- Causative/Contributing Factors
- Risk Assessment/Management Plans
- Assessment of Unit's Safety Program
- Corrective Actions and Recommendations
- Unit After-Accident Initiatives

Figure 2

ENCL

Biography/Personal Data
Name(s)

- Sex • Age • Rank
- MOS • Length in Unit
- Special Training Assignments
- Background/Training in activity performed at time of accident (e.g., Driver Training)
- Performance Indicators (Counseling Statements, bad checks, CTT scores, ADAPC files, Health Risk Assessment, etc.)
- Most Recent/Next Scheduled PCS, Training Event, Deployment
- Recent medical or mental health issues impacting soldier
- Changes of Command in Unit

Figure 3

48-Hour Sequence of Events

From 48 Hrs Prior to Time of Accident (N)

- N-48 Hours:
- N-XX Hours:
- N-XX Hours:
- N-XX Hours:
- N-XX Hours:
- N-Hour:
  - **Identify any training event being conducted at the time of the accident**
  - **List significant occurrences in life of the deceased individual in last 48 hours leading up to minutes/seconds before accident**

Figure 4

Accident Synopsis

- Date: yy/mm/dd Time: 0000 Hours
- Location (Show Map/Sketch of accident Location)
- Environmental Conditions (Day/Night, etc.)
- Other Official Civilian Agencies Accident Reports if Available (Contact LEC or SJA for assistance in obtaining reports)
- Witness Statements
- Extent/Type of Injuries sustained

Figure 5

Accident Synopsis

(Continued)

- Photos of accident scene, if possible, and photos of vehicle(s)/equipment involved in accident
- Action of victim/others and sequence of events of accident
- Emergency Response (Time to respond, who responded, where victim was taken, time/place of death, etc.)
- Time and sequence of unit/unit Commander/SDO/ Safety Office notification

Figure 6

Causative/Contributing Factors

(per DA Form 285)

- Physical description of equipment/vehicle (Include inspection documentation, vehicle/equipment service records, etc., if available--DA Form 285, Block 52)
- Use and type of safety equipment (seatbelt, antilock brakes, helmet, gloves, goggles, etc.--DA Form 285, Block 38)
- Vehicle/equipment failures/malfunctions (Provide photos, documentation of failed/malfunctioned parts, etc.--DA Form 285, Block 60)

Figure 7

Causative/Contributing Factors – Cont'd

(per DA Form 285)

- Condition of soldier (BAC, fatigue, etc.--DA Form 285, Block 41)
- Explain who performed incorrectly and how (DA Form 285, Block 47; DA Form 285-AB-R, Blocks 36b & c)
- Reasons activity was performed incorrectly (DA Form 285, Block 46; DA Form 285-AB-R, Block 37)
- Identify/describe any leadership failure

Figure 8

Unit's Safety Program Assessment

- Official/Training Holiday Safety Briefs and other Unit Safety Briefings
- Vehicle or Equipment Inspections
- Leave Policy
- Awards Program
- Unit Safety Awareness Profile (Trained Safety Officer/NCO, Posters, NCO Wallet Cards, Safety Days, Risk Management Training/ Implementation, etc.)

Figure 9

After-Accident Initiatives

- Explain how unit used lessons learned from this accident to brief unit members
- New safety programs or countermeasure initiated since accident
- Medical Interventions (Critical Incident Stress Debriefings, individual counseling, OPDs/NCODPs by Medical personnel, etc.)
- Describe actions taken, planned, or recommended to eliminate the cause(s) of this accident (from unit level to HQDA)

Figure 10