UNITED STATES AIR FORCE
GROUND ACCIDENT INVESTIGATION BOARD REPORT

Polaris Ranger Model 800 Crew All-Terrain Utility Vehicle
VIN: 4XAWH76A8D2707361

386TH EXPEDITIONARY LOGISTICS READINESS SQUADRON
386TH AIR EXPEDITIONARY WING
ALI AL SALEM AIR BASE, KUWAIT

LOCATION: Terminal Cargo Yard, Ali Al Salem Air Base, Kuwait

DATE OF ACCIDENT: 14 September 2020

TYPE OF ACCIDENT: Motor Vehicle Fatality

BOARD PRESIDENT: Brigadier General Max J. Stitzer, USAF

Conducted IAW Air Force Instruction 51-307

2 March 2021

ACTION OF THE CONVENING AUTHORITY

The formal report of the Ground Accident Investigation Board, conducted under the provisions of AFI 51-307, by Brigadier General Max J. Stitzer, Director of Staff and Associate Director to the Deputy Chief of Staff for Logistics, Engineering and Force Protection, Headquarters United States Air Force (Air Staff), into the 14 September 2020 mishap at Ali Al Salem AB, Kuwait involving Polaris Ranger Model 800 Crew All-Terrain Utility Vehicle (ATV), Vehicle Identification Number (VIN): 4XAWH76A8D2707361, located at the 386th Expeditionary Logistics Readiness Squadron, 386th Air Expeditionary Wing, is attached. The report complies with applicable regulatory and statutory guidance, and on that basis is approved.

[redacted]

BRIAN S. ROBINSON
Lieutenant General, USAF
Deputy Commander, Air Mobility Command

EXECUTIVE SUMMARY
UNITED STATES AIR FORCE
GROUND ACCIDENT INVESTIGATION

POLARIS RANGER MODEL 800 CREW® ALL-TERRAIN UTILITY VEHICLE
ALI AL SALEM AIR BASE, KUWAIT
14 SEPTEMBER 2020

The Mishap Airman (MA), a Staff Sergeant assigned to the 386th Expeditionary Logistics Readiness Squadron (386 ELRS), Ali Al Salem Air Base (ASAB), Kuwait, was fatally injured at approximately 1700 hours local time (L) on 14 September 2020 when the United States Army (USA) Polaris Ranger all-terrain utility vehicle, in which he was a passenger, was involved in a rollover accident.

On 13 September 2020, the day prior to the mishap, at approximately 1921L, the Mishap Vehicle Operator (MVO), a Staff Sergeant, assigned to the 386th Expeditionary Logistics Readiness Squadron (386 ELRS), Ali Al Salem Air Base (ASAB), Kuwait, was assigned to receive cargo from an incoming C-17 aircraft mission, REACH 815. This mission included the Mishap Vehicle (MV), a Polaris Ranger all-terrain utility vehicle to be delivered to the U.S. Army at ASAB for further downrange delivery in the United States Central Command (USCENTCOM) area of operations (AOR). After the MV was offloaded from the aircraft by the 386 ELRS Ramp Section, the MV was parked in the adjacent cargo receiving lot known as Whiskey ("W") Pad. The MVO then drove the MV from W Pad and parked it in the terminal cargo yard known as "Bay 69."

On 14 September 2020, both the MA and the MVO, reported to duty for their normal work shift from 1200 – 0000L. At approximately 1138L, a C-17 mission, MOOSE 46, arrived with cargo. The 386 ELRS Ramp Section downloaded a Jeep Cherokee ("Jeep") and a large recovery vehicle ("wrecker") from the aircraft and parked both vehicles on W Pad. The MVO subsequently sought the MA's assistance to reposition the wrecker and the Jeep from W Pad to Bay 69. The MVO drove the wrecker to the southeast corner of Bay 69 and parked it while the MA followed in the Jeep. The MVO then rode as a passenger in the Jeep back to the northwest corner of Bay 69, where the MV had been parked the previous day. The MA parked the Jeep and both Airmen exited the vehicle. The MVO then got in the driver's seat of the MV, with the MA riding as the front-seat passenger.

The MVO lost control of the MV while driving on the sand surface of Bay 69. The MV rolled over onto its passenger side while performing a sharp left-hand turn, pinning the MA underneath the protective roll cage of the MV. The MVO quickly exited the vehicle through the protective roll cage as it rolled onto its passenger side. Once the MVO landed on the ground, he turned around and observed the MA pinned underneath the protective roll cage. The MVO attempted to lift the MV off of the MA, but he was unable to lift the MV nor elicit a response from the MA. Using his personal cell phone, the MVO called his work center supervisor and requested emergency assistance. A Security Forces (SF) patrol and the Fire Chief responded to the scene of the mishap at 1702L. At 1706L, emergency medical personnel arrived and the responding physician declared the MA deceased at 1711L.

SUMMARY OF FACTS
Polaris Ranger Model 800 Crew All-Terrain Utility Vehicle
VIN: 4XAWH76A8D2707361
Ali Al Salem Air Base, Kuwait
14 September 2020

TABLE OF CONTENTS

ACRONYMS AND ABBREVIATIONS

5 EAMS	5th Expeditionary Air Mobility Squadron
28 ECAB	28th Expeditionary Combat Aviation Brigade
28 ID	28th Infantry Division
42 APS	42nd Aerial Port Squadron
386 AEW	386th Air Expeditionary Wing
386 ELRS	386th Expeditionary Logistics Readiness Squadron
386 EMDG	386th Expeditionary Medical Group
386 ESFS	386th Expeditionary Security Forces Squadron
A1C	Airman First Class
AAF	Army Air Field
AB	Air Base
ACA	Airman Comprehensive Assessment
ADLS	Advanced Distributed Learning Service
AEW	Air Expeditionary Wing
AEWI	Air Expeditionary Wing Instruction
AFB	Air Force Base
AFCENT	Air Forces Central
AFI	Air Force Instruction
AFJIS	Air Force Judiciary Information System
AFLOA	Air Force Legal Operations Agency
AFLOA/JACC	Claims and Tort Litigation Division, Air Force Legal Operations Agency
AFMAN	Air Force Manual
AFSC	Air Force Specialty Code
AIB	Accident Investigation Board
ALUMMC	Aviation Light Utility Mobile Maintenance Cart
AMC	Air Mobility Command
AMCI	Air Mobility Command Instruction
AOR	Area of Responsibility
APOD	Aerial Port of Debarkation
APOE	Aerial Port of Embarkation
APS	Aerial Port Squadron
ARB	Air Reserve Base
AROWS	Air Reserve Orders Writing System
ASAB	Ali Al Salem Air Base
ASP	Ammunition Supply Point
ATOC	Air Transportation Operations Center
ATTLA	Air Transportability Testing Loading Agency
AT	All-Terrain
ATOC	Air Terminal Operations Center
ATV	All-Terrain Vehicle
ALUMMC	Aviation Light Utility Mobile Maintenance Cart
BDOC	Base Defense Operations Center
BP	Board President
CBT	Career Based Training
CC1	Commander 1
CC2	Commander 2
CCIP	Commander’s Inspection Program
CCIR	Commander’s Critical Information Requirement
CDC	Career Development Course
CED	Contingency, Exercise and Deployment
CES	Civil Engineering Squadron
CFETP	Career Field Education Training Plan
CGO	Company Grade Officer
CO-W1	Co-Worker 1
CO-W2	Co-Worker 2
CO-W3	Co-Worker 3
CO-W4	Co-Worker 4
CO-W5	Co-Worker 5
CO-W6	Co-Worker 6
CO-W7	Co-Worker 7
CONUS	Continental United States
COVID	Coronavirus Disease 2019
CSS	Command Support Staff
DFAC	Dining Facility
DHA	Defense Health Agency
DO	Director of Operations

DOA	Dead on Arrival
DOC1	Doctor 1
DOC2	Doctor 2
DoD	Department of Defense
DoDI	Department of Defense Instruction
DOS	Date of Separation
DOT	Department of Transportation
DTR	Defense Transportation Regulation
ECAB	Expeditionary Combat Aviation Brigade
ECC	Emergency Control Center
ECP	Entry Control Point
EDT	Eastern Daylight Time
ELRS	Expeditionary Logistics Readiness Squadron
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EMT1	Emergency Medical Technician 1
EMT2	Emergency Medical Technician 2
EMT3	Emergency Medical Technician 3
EPR	Enlisted Performance Report
FTAC	First Term Airman Course
GAIB	Ground Accident Investigation Board
GATES	Global Air Transportation Execution System
GMV	Government Motor Vehicle
GOV	Government Owned Vehicle
GVWR	Gross Vehicle Weight Rating
GTC	Government Travel Card
HAZMAT	Hazardous Material
HCOF	Health Care Operations Flight
HQ USAF/JAOA	Aviation and Admiralty Torts Division, Headquarters United States Air Force
HRA	Health Readiness Assessment
IAW	In Accordance With
ICAO	International Civil Aeronautical Organization
IFAK	Individual First Aid Kit
INV1	Investigator 1
INV2	Investigator 2
INV3	Investigator 3
IPTS	In-Patient Training Squadron
ISB	Interim Safety Board
ITP	Individual Training Plan
JA	Judge Advocate
JBSA	Joint Base San Antonio
JI	Joint Inspection
JPAS	Joint Personnel Adjudication System
JTSO	Job Training Safety Outline
KIA	Killed in Action
L	Local
LA	Legal Advisor
LMR	Land Mobile Radio
LOI	Letter of Instruction
LRS	Logistics Readiness Squadron
MA	Mishap Airman
MCT	Movement Control Team (Army)
MD	Medical Member
MFR	Memorandum for Record
MHE	Material Handling Equipment
MICT	Management Internal Control Toolkit
MMHE	Mechanized Material Handling Systems
MPH	Miles per Hour
MSL	Mean Sea Level
MSgt	Master Sergeant
MV	Mishap Vehicle
MVO	Mishap Vehicle Operator
MWR	Morale, Welfare, Recreation
NCOIC	Non-Commissioned Officer in Charge
NIPR	Non-Classified Internet Protocol Router Network
NSN	National Stock Number
NUR1	Nurse 1
OAFME	The Office of the Armed Forces Medical Examiner
OCP	Operational Camouflage Pattern
OEM	Original Equipment Manufacturer
OGMVC	Other Government Motorized Vehicle Conveyances
OJT	On-The-Job Training
OM	Operations Maintenance
ORM	Operational Risk Management
OSI	Office of Special Investigations
OTC	Over-The-Counter
OTR	Over-The-Road
PA	Public Affairs

PA ARNG	Pennsylvania Army National Guard
PPE	Personal Protective Equipment
QA	Quality Assurance
QRT	Quick Response Team
QTP	Qualification Training Package
REC	Recorder
RIPTOA	Relieve in Place Transfer of Authority
RM	Risk Management
SAFE1	386 ELRS Safety Representative
SAV	Staff Assistance Visit
SF	Security Forces
SF1	Security Forces 1
SF2	Security Forces 2
SF3	Security Forces 3
SF4	Security Forces 4
SF5	Security Forces 5
SF6	Security Forces 6
SF7	Security Forces 7
SF8	Security Forces 8
SF9	Security Forces 9
SIB	Safety Investigation Board
SIPR	Secret Internet Protocol Router Network
SJA	Staff Judge Advocate
SUP1	Supervisor 1
SUP2	Supervisor 2
SUP3	Supervisor 3
SUP4	Supervisor 4
SUP5	Supervisor 5
SURF	Single Unit Retrieval Format
TBA	Training Business Area
TCP	Tactical Control Point
TF ANVIL	Task Force Anvil
TO	Technical Order
UDM	Unit Deployment Manager
ULN	Unit Line Number
USA	United States Army
USAF	United States Air Force
U.S.C.	United States Code
USCENTCOM	United States Central Command
USR	Unit Safety Representative
USTRANSCOM	United States Transportation Command
UTC	Unit Type Code
UTM	Unit Training Manager
UTR	Unit Travel Representative
VCO	Vehicle Control Officer
VIN	Vehicle Identification Number
VSA	Vehicle Search Area
W	Whiskey
WVARNG	West Virginia Army National Guard

SUMMARY OF FACTS

1. AUTHORITY AND PURPOSE

a. Authority

On 13 November 2020, Lieutenant General Brian S. Robinson, Deputy Commander, Air Mobility Command (AMC), appointed Brigadier General Max J. Stitzer, United States Air Force (USAF), as Board President of a Ground Accident Investigation Board (GAIB) to investigate the death of the Mishap Airman (MA) (Tab Y-3). The GAIB was convened on 2 December 2020 and was conducted in accordance with Air Force Instruction (AFI) 51-307, *Aerospace and Ground Accident Investigations*, dated 18 March 2019 (Tab Q-5). Additional members of the board included a Legal Advisor (Captain), Medical Advisor (Captain), and Recorder (Senior Airman) (Tab Y-3).

b. Purpose

In accordance with AFI 51-307, *Aerospace and Ground Accident Investigations*, this Ground Accident Investigation Board conducted a legal investigation to inquire into all the facts and circumstances surrounding this Air Force ground accident, prepare a publicly releasable report, and obtain and preserve all available evidence for use in litigation, claims, disciplinary action, and adverse administrative action.

2. ACCIDENT SUMMARY

The MA, a Staff Sergeant assigned to the 386th Expeditionary Logistics Readiness Squadron (386 ELRS), Ali Al Salem Air Base (ASAB), Kuwait, was fatally injured at approximately 1700 hours local time (L) on 14 September 2020 when the United States Army (USA) Polaris Ranger all-terrain utility vehicle, in which he was a passenger, was involved in a rollover accident (Tab B-3 to B-4). Emergency medical personnel responded to the mishap scene at approximately 1711L and the MA was declared dead on arrival (DOA) (Tabs O-6 and V-28.3). The Mishap Vehicle Operator (MVO), also a Staff Sergeant assigned to the 386 ELRS, sustained minor injuries, was treated, and later released by medical personnel (Tabs B-3 to B-4, O-6, and V-29.2). Prior to deployment, the MA was a reservist assigned to the 42nd Aerial Port Squadron (42 APS), Westover Air Reserve Base, Massachusetts (Tabs B-3 to B-4 and T-5). The MVO was active duty and assigned to the 437th Aerial Port Squadron (437 APS) Joint Base Charleston, South Carolina (Tabs B-4 and Tab T-25).

3. BACKGROUND

a. Air Mobility Command (AMC)

This mishap took place while the MVO was temporarily deployed to ASAB, Kuwait (Tab B-3 to B-4 and B-7). However, the MVO is permanently assigned to Joint Base Charleston, South Carolina, an AMC installation (Tabs B-4 and Tab T-25).

The mission of AMC is to provide rapid global mobility and enable global reach – the ability to respond anywhere in the world in a matter of hours (Tab CC-3). As the air component of United States Transportation Command (USTRANSCOM) and the Air Force's oldest command, its vision is to develop Air Mobility Warriors that project decisive strength across contested domains and deliver hope…always (Tab CC-3). AMC is comprised of 110,000 Total Force personnel and ten (10) installations (Tab CC-4). The command operates the C-5 Galaxy, KC-10 Extender, C-17 Globemaster III, C-130 Hercules, C-130J Super Hercules, and KC-135 Stratotanker (Tab CC-4). Operational support aircraft include the VC-25 (Air Force One), C-20, C-21, C-32, C-37, and C-40 (Tab CC-4). Command headquarters are located at Scott Air Force Base, Illinois (Tab CC-3).

b. Ninth Air Force (Air Forces Central)

Ninth Air Force (9AF) or Air Forces Central (AFCENT) is the air component of United States Central Command (USCENTCOM), a regional unified command (Tab CC-7). AFCENT delivers dominant coalition air power to secure and stablize the USCENTCOM's 20-nation area of responsibility (AOR) in Southwest Asia (Tab CC-7). Nation states included in AFCENT's AOR are Afghanistan, Iran, Iraq, Kuwait, Qatar, and Syria (Tab CC-8).

c. 386th Air Expeditionary Wing (386 AEW)

The 386 AEW is the primary airlift gateway for delivering combat power to joint and coalition forces in the USCENTCOM AOR (Tab CC-9). It is headquartered at ASAB (Tab CC-9). ASAB and nearby Cargo City, Kuwait, support Operations INHERENT RESOLVE and FREEDOM'S SENTINEL, making both aerial ports the busiest in the AOR (Tab CC-9). The two (2) ports average 600 airlift missions per month and move roughly 68,000 tons of cargo and 125,000 personnel per year (Tab CC-9).

d. 386th Expeditionary Logistics Readiness Squadron (386 ELRS)

The 386 ELRS provides full-spectrum logistics support to theater-wide distribution, materiel management, and contingency operations (Tab CC-18 and CC-21). The ELRS is comprised of the Aerial Port, Deployment and Distribution, Vehicle Management, Fuels Management, and Material Management Flights (Tab CC-21 and CC-23). The 386th Aerial Port Flight is at the center of deployment and redeployment of passenger and cargo movement in the AFCENT AOR and averages 6,600 passengers and 4,900 tons of cargo per month (Tab CC-21 and CC-23).

e. Aerial Port Flight (A-Flight)

Aerial Port squadrons are normally stationed within the continental United Sates (CONUS) as stand-alone squadrons (Tab BB-6). However, in the case of expeditionary locations such as ASAB, the Aerial Port is organized as a flight subordinate to the ELRS (Tabs BB-6, CC-18, CC-21, and CC-23). A-Flight functions and their roles include:

(1) Air Freight Operations Section ("Supervision")

This section supervises the subordinate sections of Ramp Operations, Special Handling, and Mechanized Handling Equipment (Tab BB-6 and BB-8).

(2) Air Terminal Operations Center (ATOC)

This section serves as the Aerial Port informational focal point for air transportation operations and provides operational command and control by dispatching data to appropriate work centers (Tabs BB-24 and CC-25). The ATOC prioritizes workload and provides tactical mission oversight to work centers (Tab BB-24). For the 386 ELRS, the local command post serves as the base informational focal point and hosts the ATOC at ASAB (Tabs BB-24 and CC-25).

(3) Ramp Services Section

The Ramp Services section is responsible for ensuring that all manifested cargo and mail are loaded and unloaded during aircraft parking operations (Tab BB-22 to BB-23).

(4) Special Handling Section

This section is responsible for managing the inventory of all special handling cargo, including nuclear materials and registered mail (Tab BB-17). Special cargo includes any cargo requiring special handling such as temperature-sensitive medical products or hazardous materials (Tab BB-18). The Special Handling Section is responsible for movement of all special cargo unless otherwise directed by local management (Tab BB-18). Both the MA and MVO were assigned to the Special Handling Section (Tab R-148 and R-158).

(5) Load Planning Section

This section is responsible for planning, selecting, sequencing, and manifesting cargo and/or mail on airlift missions while maximizing aircraft utilization and safety of flight (Tab BB-25). Load planners physically inspect outbound cargo and mail to ensure airworthiness and compliance with aircraft limitations (Tab BB-26).

(6) Mechanized Materiel Handling Systems (or Equipment) Section (MMHE or MHE)

This sections maintains and services MHE assigned and operated by the organization (Tabs BB-6 to BB-7, CC-21, and CC-23). Examples of MHE include forklifts, aircraft stairs trucks, and motorized pallet-loading and conveyor system vehicles (e.g. "Tunner" and "Halvorsen") (Tabs BB-27, CC-125, CC-127, and CC-129).

Figure 1 – Tunner 60k Aircraft Cargo Loader/Transporter (Tab CC-129)

f. 28th Expeditionary Combat Aviation Brigade (28th ECAB)

The mishap vehicle (MV) was owned by the 2nd Battalion, 104th Aviation Regiment, a subordinate unit of the 28th ECAB, United States Army (USA) (Tabs D-3, D-19, and Z-17). The 28th ECAB is a heavy aviation unit of the Pennsylvania Army National Guard (PA ARNG) and one (1) of five (5) brigades of the 28th Infantry Division (28th ID) (Tab CC-91). The unit provides assets for both federal and state active duty missions (Tab CC-91). ECAB aviators fly the AH-64 Apache, UH-60 Black Hawk, UH-72 Lakota, and CH-47 Chinook helicopters (Tab CC-91). ECAB headquarters are located at Muir Army Airfield at Fort Indiantown Gap, Pennsylvania (Tab CC-91). There are several subordinate units within the organization, including Headquarters and Headquarters Company (HHC), 2-104th General Support Aviation Battalion (2-104th GSAB), and 628th Aviation Support Battalion (628th ASB) (Tab CC-91). Subordinate units of the 2-104th GSAB are part of the West Virginia Army National Guard (WV ARNG) and include 1st Battalion, Company C; 2nd Battalion, Detachment 3, Company D (Engineering) and Company E (Tab CC-141 to CC-142). The MV was traveling downrange with 1st Battalion, Company C (Tabs D-3, D-19, Z-17, and EE-9).

Figure 2 – Polaris Ranger Model 800 Crew (Tab CC-131)

The MV, a commercially-procured Polaris Ranger Model 800 Crew, is designated by the Army as an Aviation Lightweight Utility Maintenance Management Cart (ALUMMC), which provides the USA with a logistically supportable transportation system for maintenance personnel, tools, parts, and ancillary equipment on airfields and field locations (Tab CC-131 and CC-133 to CC-135).

4. SEQUENCE OF EVENTS

a. Mission

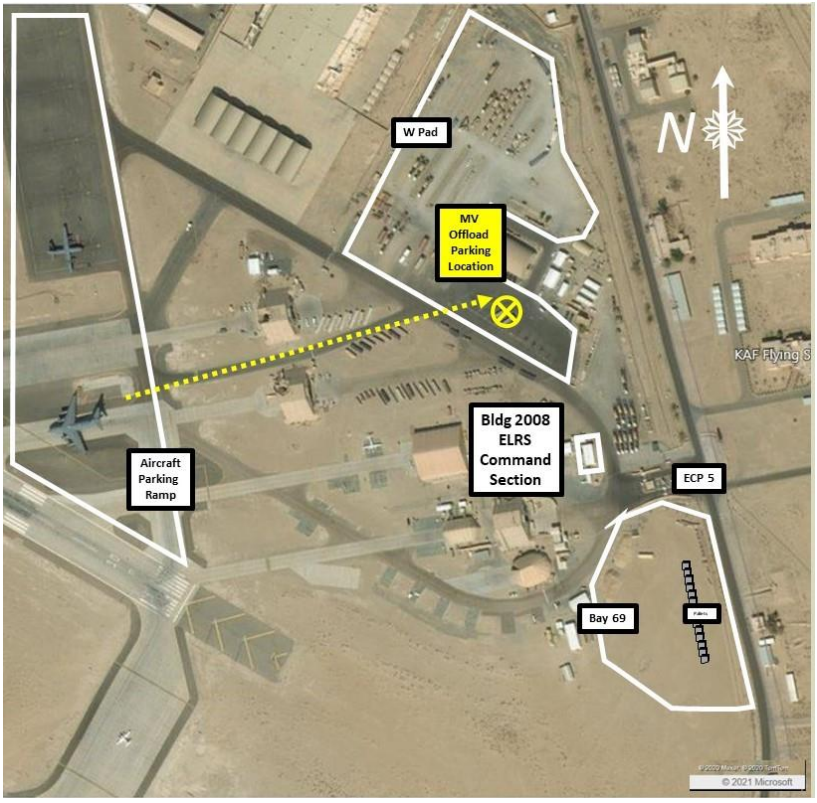

Figure 3 – Transit Route: Aircraft Parking on Flight Line to Whiskey Pad (Tab Z-3)

On 13 September 2020, at approximately 1921L, an incoming C-17 aircraft mission, REACH 815, arrived at ASAB with cargo, which included the MV (Tab K-3 and K-5). Assigned personnel in the 386 ELRS Ramp Section downloaded the MV and parked it in the designated staging area for vehicles arriving at ASAB, known as Whiskey (W) Pad (Tabs K-3, R-44, R-62, R-90, R-158, R-175 to R-176, and V-3.20). Later that evening, the MVO, assigned to 386 ELRS, A-Flight, Special Handling Section, drove the MV as a part of his routine duties of movement of incoming cargo from W Pad to the appropriate terminating cargo yard known as Bay 69 (Tab R-127, R-155 to R-161, and R-175 to R-176). The MVO noted that the MV was experiencing some mechanical issues and was "sputtering," which he attributed to the carburetor (Tab R-160 to R-162 and R-177). At the time of this initial operation of the MV, no communication was made to the Vehicle Maintenance Flight or to the MVO's supervisors about the concern (Tab R-67 and R-161). Prior to completion of his shift at 0000L on 14 September 2020, the MVO had terminally parked the MV in the northwest corner of Bay 69 (once cargo has arrived at its final destination and is removed from an aircraft, it is considered "terminal" when placed in its final parking spot waiting to be received by the end user) (Tab R-159 to R-161 and R-175). The MV was awaiting pick-up by the USA for

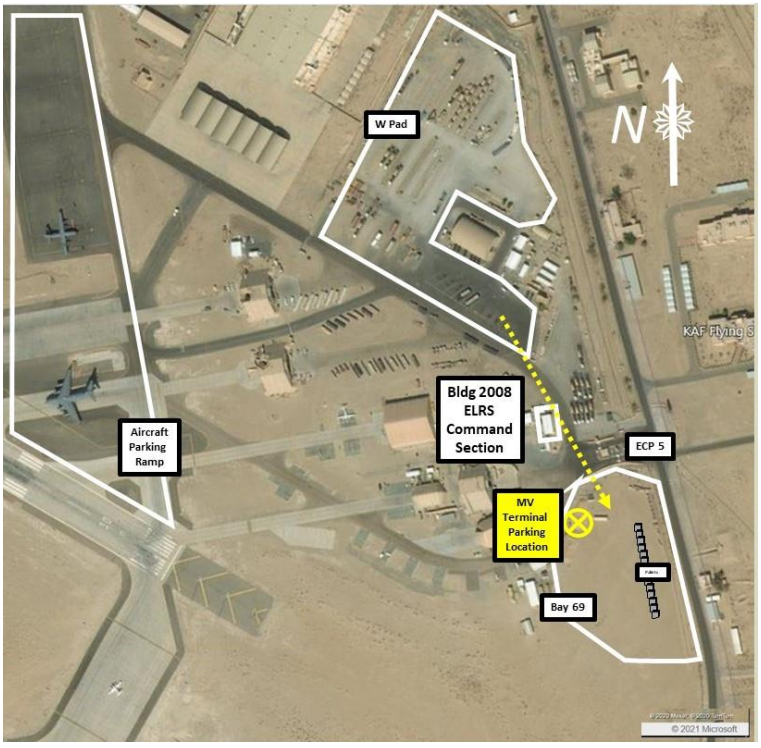

Figure 4 – Transit Route: Whiskey Pad to Bay 69 Terminal Parking (Tab Z-5)

further downrange disposition in the USCENTCOM AOR (Tab D-3 and D-19).

b. Pre-Mishap Events

On 14 September 2020, the MVO followed his usual routine and arrived for duty between 1145L and 1150L to the Special Handling Section of the 386 ELRS Aerial Port for his normal work shift from 1200 – 0000L (Tab R-147 and R-152). Just prior to the shift change at approximately 1138L, a C-17 mission, MOOSE 46, had arrived with cargo that included a Jeep Cherokee ("Jeep") and a large recovery vehicle ("wrecker") (Tab K-9 and K-11). The cargo was subsequently downloaded from the aircraft by 386 ELRS Ramp Section members and parked in W pad awaiting terminal parking by members of the Special Handling Section (Tabs R-44, R-62, R-90, R-158, and V-3.20). While the MOOSE 46 cargo was being downloaded, members from Special Handling were engaged in other shift-related duties (Tab R-152 to R-155, R-189, and R-203). The MVO and the MA, along with the other members on shift, participated in the shift change brief before helping to drive the opposite shift workers back to their dorms (Tab R-153). From 1330 – 1400L the MVO had a meal at the Silver Bullet, the dining facility on base (Tab R-153 and R-155). After finishing his meal, the MVO returned to the Special Handling office, Building 2034, and waited to be dispatched to move incoming cargo (Tab R-155). At approximately 1500L, the MVO participated in a mock Joint Inspection (JI) on an M1 Abrams Tank (Tab R-75, R-156, and R-202). The inspection, which satisfies training requirements for Special Handling members, was estimated to take approximately one (1) hour (Tabs R-74 to R-75, R-156, V-7.11 to V-7.12, and V-13.23).

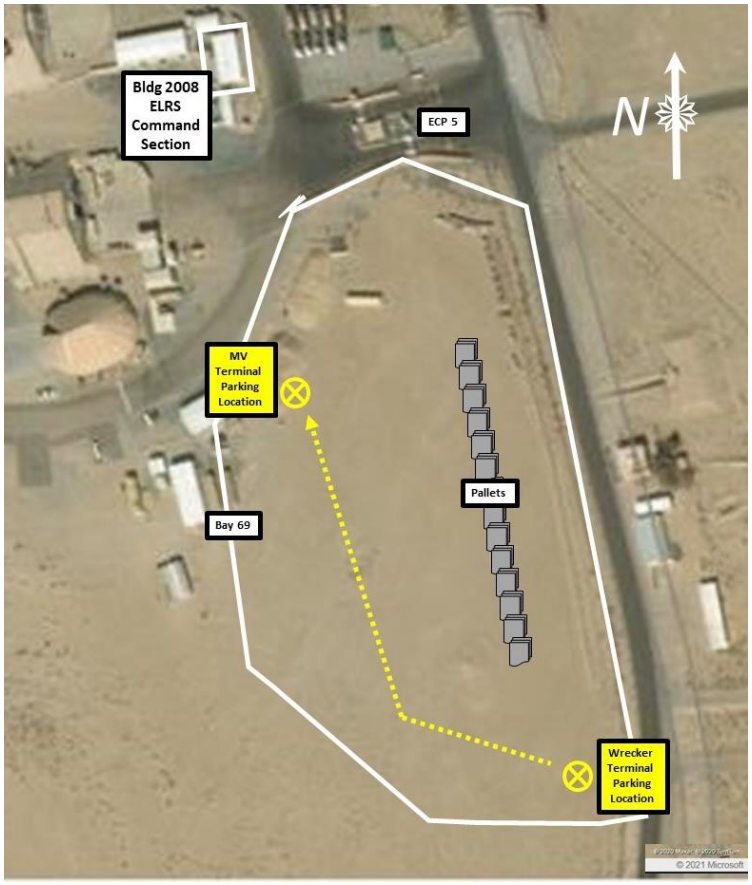

Figure 5 – Transit Route: Wrecker Parking to Parked Polaris (Tab Z-7)

After the mock JI was complete, the MVO and the MA returned to the Special Handling office (Tab R-156 and R-203). At approximately 1617L, the MVO sent a text message on his personal cell phone to his supervisor, SUP1, containing a video of SUP1 driving the M1 Abrams Tank from the earlier JI (Tab R-92 and R-204). SUP1 subsequently left the Special Handling office at 1620L to start a second JI at a distant site (Tabs R-73, R-88, R-92, and V-8.3). Shortly thereafter, the MVO was notified of the downloaded cargo from MOOSE 46 (the Jeep and the wrecker) awaiting transportation from W Pad to Bay 69 (Tab R-158 and R-203). The MVO went to W Pad to evaluate the cargo (Tab R-158). After inspection of the vehicles and verification of the appropriate

paperwork, the MVO sought the MA's assistance in relocating the vehicles (Tab R-157 and R-203). The MVO drove the wrecker to the southeast corner of Bay 69 and the MA followed behind him in the Jeep (Tab R-159 and R-189 to R-190). After the MVO parked the wrecker, he then rode with the MA in the Jeep back towards the front northwest end of the lot (Tab R-160 and R-190 to R-191).

During this ride, the MVO discussed with the MA the intent to drive the MV again in order to troubleshoot the original concerns regarding the MV's serviceability (Tab R-160 and R-191). The MA parked the Jeep next to the MV in the northwest corner of the lot, and both Airman exited the vehicle (Tab R-158 and R-191). The MVO then started driving the MV with the MA as the front-seat passenger (Tab R-160).

Figure 6 – MV's Terminally Parked Location (Tab S-7)

The MVO then decided to drive a lap around Bay 69 (Tab R-160 and R-191). Neither the MVO nor the MA were wearing seatbelts, helmets, eye protection, or long-sleeved shirts (Tabs R-165 to R-167 and DD-9). Of the 386 ELRS members interviewed, none were aware of the locations or actions of the MVO or MA at that time, with the exception that they were moving cargo (Tabs R-40, R-69 to R-73, V-3.20, V-5.3, V-8.6, V-11.2, and V-15.16).

When the MVO initially started the MV, the MVO pulled out of where the MV was parked, turned right and "opened up" as the MV traveled south down a straightaway section of the lot until reaching the south end where the mishap occurred (Tab R-160, R-164, R-182, and R-184).

Figure 7 – MV's Tracks Pulling out of Terminally Parked Location (Tab S-9)

c. Summary of Mishap

On 14 September 2020, at approximately 1700L, the MVO lost control of the MV while making a 180-degree left hand turn on the sand surface of the southeast corner of Bay 69, with the MA riding in the front passenger seat (Tabs N-3, N-5, R-164 to R-165, S-11, and V-21.3 to V-21.4). The MVO reported taking his foot off of the gas prior to the turn (Tab R-164 and R-194). He did not recall using the brake (Tab R-164 and R-194). The MVO estimated he was going approximately 15 miles per hour (mph) at the time (Tab R-164).

While performing the turn, the MV began to roll onto two (2) wheels (Tab R-182 and R-194). The MVO attempted to make a correction with the steering wheel at that time (Tab R-145, R-164, and R-183). When the steering correction was determined to be ineffective in placing the MV in an upright position, the MVO quickly exited the passenger compartment of the MV through the protective roll cage (Tab R-145 and R-165). The MA appeared to attempt an unsuccessful jump from the passenger side of the vehicle, prior to the MA becoming pinned between the protective roll cage of the MV and the ground (Tab R-145, R-165, and R-195). The MV did not complete a full roll, but instead landed on its passenger side (Tabs S-11, V-21.3, and V-28.3). Once the MVO landed on the ground, he turned around and observed the MA pinned underneath the protective roll cage (Tab R-165 and R-195). The MVO attempted to lift the MV off of the MA, but due to the weight of the vehicle, was unsuccessful in doing so (Tab R-165 and R-195). The MVO was also unable to elicit a response from the MA, nor was he able to locate a pulse (Tab R-165 and R-195 to R-196). The unresponsive nature of the MA was consistent with post-mishap medical findings that the MA likely passed away instantaneously (Tab V-28.3 and V-28.9).

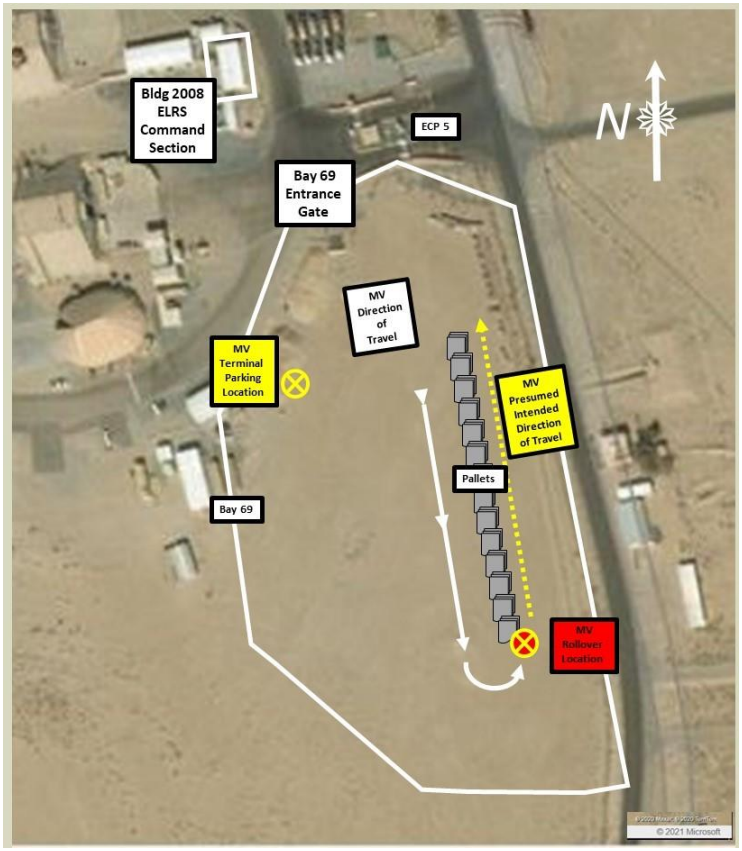

Figure 8 – MV's Direction of Travel (Tab Z-9)

Figure 9 – MV's Tire Tracks While Attempting Left Hand Turn (Tab S-5)

d. Post-Mishap Events

(1) Search and Rescue

At approximately 1652L, the MVO called SUP1 to request emergency assistance using his personal cell phone that was connected to a personal hot spot ("Wi-Fi puck") (Tabs R-69, R-165, R-196, and V-8.3). On the day of the

mishap, both the MA and the MVO had Land Mobile Radios (LMRs) assigned to them, and the MVO reported bruising on his hip related to the wear of the radio during the mishap (Tab R-93 and R-165 to R-166). However, the MVO did not use his LMR to call for assistance (Tab R-165 and R-196). After receiving the call from the MVO, SUP1 began travel from his location to Bay 69 in a Jeep, a vehicle assigned to ELRS, and instructed a USA member nearby to call 911 (Tabs R-69, R-88, V-8.3, and V-21.9). SUP1 also requested help from the Security Forces (SF) members stationed at Entry Control Point (ECP) 5, a flight line security gate located immediately outside of Bay 69 (Tabs V-8.4 and V-21.9). An emergency response was initiated by SF at 1655L (Tabs N-5 and O-4 to O-5). SF1 and SF2, first responders from SF, arrived on scene at 1702L, where the MA was noted to be DOA (Tabs N-3, O-6, R-106, R-111, and R-140). The MA was trapped underneath the passenger side of the MV, with the roll cage on top of him (Tabs R-165, R-195, V-21.3, V-21.5, and V-28.3). The MA was wearing his short-sleeved coyote brown undershirt, operational camouflage pattern (OCP) trousers, coyote brown military boots, and a boonie hat (Tab DD-9). The MA was not wearing a helmet, eye protection, or a seatbelt (Tabs DD-9, V-21.6, and V-28.3).

When SF1 and SF2 arrived on scene, the MVO was visibly upset and shaken from the incident (Tabs R-105, R-112, R-139, V-5.3, and V-8.6). The MVO told SF1 and SF2 that he "wasn't going to lie to them" and that he and the MA were "just out joy-riding" (Tabs R-106, R-112, V-21.6, and V-21.11). The MVO also stated that they "hit the turn too hard" prior to the MV tipping over (Tab R-139). While additional responders arrived on scene, the MVO sat on the back of a pick-up truck with SUP2 and SUP4, members of 386 ELRS leadership, who had responded to cellphone notifications from SUP1 (Tabs R-37 to R-38, R-119 to R-121, V-3.3, and V-5.3). To his leadership, the MVO expressed regret and sentiments that the mishap was "his fault" but did not give any indication as to what he and the MA were doing in the MV prior to the rollover (Tabs R-40, R-65, R-120, R-139, V-10.4, V-10.11, and V-20.6).

Time of death of the MA was declared at 1711L by DOC1, the ASAB Medical Director and responding physician (Tabs N-3 and O-6). After initial evaluation of superficial wounds by the responding medics, EMT1 and EMT2, the MVO was released from the scene at 1711L and subsequently taken to the medical clinic for additional evaluation at 1722L (Tabs N-3, O-6, and DD-7). Besides EMT1 and EMT2, no other individuals accompanied the MVO to the clinic (Tab V-31.6 and V-33.5). However, CO-W1, a 386 ELRS coworker, was sent to wait with the MVO so he would not be at the clinic by himself (Tabs R-38, R-66, R-119, and V-11.5). SUP2 later joined CO-W1 and the MVO in the clinic (Tab V-11.5). CO-W1 eventually had to return to his work shift and was later replaced by CO-W3, another member of the 386 ELRS (Tabs R-38, R-66, and V-11.5). While in the clinic, the MVO was evaluated by DOC2, the ASAB flight surgeon, and was determined to have minor injuries not requiring additional follow-up (Tab V-29.2).

(2) Recovery of Remains

At 1814L, Mortuary Affairs removed the deceased MA from the scene and an autopsy later determined the cause of death was blunt force injuries to the head (Tabs N-3, O-6, and DD-8).

e. Post-Mishap Investigation

At approximately 1723L, INV1, a SF Criminal Investigator, and INV2, a SF Traffic Investigator, arrived on scene to evaluate and preserve evidence and perform measurements of the MV's tire tracks (Tabs O-17, O-19, O-21, V-21.5, and V-24.5). These measurements were later used to calculate the speed of the MV based on the tire impressions in the sand (Tabs O-11, O-13, O-15, O-21, and V-24.5). Tire tracks that matched the MV were located at its original parking spot at the northwest end of Bay 69, near the location of the parked Jeep (Tabs R-159 to R-160 and S-9). The tracks appeared to head south from the Jeep, along a straightaway section on the west side of the lot (Tab S-9). For much of the distance between the initial track markings near the Jeep and the final turn, the tracks were undetectable (Tabs O-11, V-24.6, and V-24.13). However, matching tracks again appeared leading up to the MV at the south end of Bay 69, demonstrating the final 180-degree turn of the vehicle (Tabs O-11, O-17, O-19, V-21.4, V-24.10, and V-28.4).

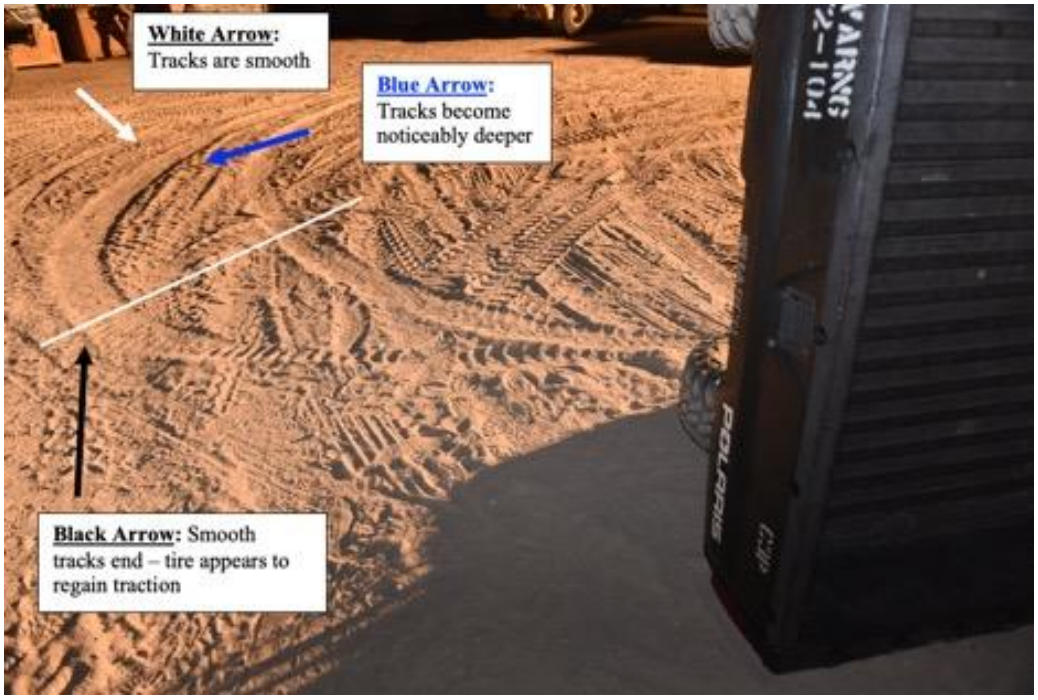

Figure 10 – Depth and Smoothness of MV Tire Tracks (Tab Z-11)

The final track length was approximately 30 feet following along the curve of the turn (Tabs O-17, O-19, O-21, and V-24.14). The tracks became noticeably deeper while simultaneously becoming smooth after executing approximately 90 degrees of the turn, which INV2 evaluated as the moment when danger was first detected by the MVO and likely when he slammed on the brakes and caused the vehicle to "drift" (note: drifting is when the rear tires swing out past the front tires of the vehicle and is caused by excessive speeding, braking, and turning all at the same time) (Tab V-24.6, V-24.16, and V-24.20 to V-24.21). In noting the depth of the tracks, INV1 and INV2 also observed the abruptness of the angle of the turn being suggestive of a tight

Figure 11 – Speed Limit Sign in W Pad (Tab Z-13)

and fast turn, especially for the type of vehicle being driven and the sand surface being driven on (Tab V-21.4 to V-21.5, V-24.10, and V-24.19). Multiple sources who observed the tracks on scene remarked on the apparent sharp nature of the turn that was being attempted (Tab V-16.5, V-18.3, V-20.9, V-21.4 to V-21.5, V-21.14 to V-21.15, V-23.4, V-24.10, V-24.20, V-25.4, V-28.4, and V-28.9). Approximately 120 degrees into the turn, there were no longer two tracks indicating a vehicle traveling on four (4) wheels, but instead only one set of tracks leading up to where the MV was resting on its passenger side (Tabs O-11, S-13, and Z-11). Based on the track measurements and tire marks, INV2 later calculated the speed of the MV to be between 25 and 35 mph (Tabs O-17, O-19, V-24.5, 24.10, and V-24.18). The speed limit in all areas near the cargo lot and the flight line was 5 mph (Tabs V-2.24, V-4.16, V-15.13, Z-13 and Z-15).

Figure 12 – Speed Limit Sign Near Flight Line (Tab Z-15)

The only obvious damage to the vehicle after the mishap was a few small scuff marks on the vehicle frame on the passenger side (Tabs P-3, V-21.4, V-24.12, and Z-21). Additionally, the plastic cover of the emergency brake handle had broken off and was lying on the ground next to the MV (Tabs R-194 and S-17). When the MV came to rest, it landed approximately six (6) to fifteen (15) feet from the end of a row of concrete slab with cargo pallets piled on top (Tabs O-17, O-19, S-13, and V-24.11). The location of the MV upon coming to its final resting position was such that if the MV were to have continued on its course, it would have run directly into the pallets (Tabs O-17, O-19, S-13, and V-24.11). INV1 and INV2 indicated there were no other obvious hazards found along the path of the tire tracks or in the surrounding area of the MV (Tab V-20.4, V-24.10, V-24.18, and V-27.5). Immediately following the mishap, INV1 spoke with SUP1, who stated it was not uncommon for A-Flight members to drive "toys" around anytime they could get their hands on them (Tab V-21.7 and V-21.20). SUP1 also stated that "anytime they get equipment, they take it for a ride" (Tab V-21.7 and V-21.20). Neither INV1 nor INV2 were able to interview the MVO at the scene, as he had already been released and taken to the clinic prior to their arrival (Tabs V-21.6, V-21.8, V-21.10, and V-24.16).

Figure 13 – Landing Position of MV in Front of Cargo Pallets (Tab S-13)

Personnel from the Office of Special Investigations (OSI) later arrived on scene (Tab O-6). After completing an initial assessment of the mishap, OSI determined there was no evidence of foul play, criminal activity, or malicious intent, and therefore, the motor vehicle fatality did not fall within their jurisdiction (Tab EE-3). The required Operator's Report of Motor Vehicle Accident Form (Standard Form 91) was never completed by the MVO, nor was the required Supervisor Mishap Report (AF Form 978) filled out by any of the MVO's supervisors (Tabs V-2.21 to V-2.22, V-3.18 to V-3.19, and BB-52). A SF report submitted two (2) days post-mishap, indicated the base legal office determined there was no probable cause based on the evidence available at the time and no criminal investigation was pursued (Tabs V-21.6, V-21.7, and V-21.20 to V-21.21).

f. Post-Mishap MVO Actions

After evaluation at the medical clinic by MD2, the MVO was taken back to his dorm by SUP2 and CO-W3 (Tab V-11.5). The MVO was cooperative with questioning in three (3) additional interviews conducted by the Safety Investigation Board (SIB) prior to leaving the country (Tab R-147 to R-174, R-175 to R-185, and R-189 to R-196). He was seen again in the clinic for the standard post-deployment evaluation (DHRA2), during which no significant information regarding the mishap was gathered (Tabs DD-7 and V-28.8). On 22 September 2020, eight (8) days after the mishap, the MVO left Kuwait (Tab EE-7). After arriving back at home station, the MVO was cooperative with one (1) additional SIB interview on 8 October 2020, however, he declined to provide further input to the subsequent GAIB (Tabs R-201 to R-206, V-34.1 to V-34.2, and DD-3 to DD-4).

5. MAINTENANCE

In accordance with (IAW) AFMAN 24-306, *Operation of Air Force Government Motor Vehicles*, paragraphs 6.6, 6.8, and 6.8.1, servicing USAF Aerial Port personnel are not authorized to perform any maintenance outside the operator's responsibility of before-, during-, and after-operations inspections and are required to immediately report any defects that exceed the operator's responsibility (Tab BB-142). Additionally, per Defense Transportation Regulation 4500.9-R Part III, *Mobility*, owning units are responsible for servicing their vehicles that arrive as cargo (Tab BB-122). Leadership and supervisors of the MVO confirmed in testimony that such practice is not allowed nor condoned (Tabs R-45, R-67 to R-68, V-2.20, V-2.23, V-3.18, V-7.17 to V-7.21, and V-8.20 to V-8.21).

However, according to the MVO, he told his coworkers he noticed the MV was sputtering after it was offloaded on 13 September 2020, and the MVO stated that he intended to troubleshoot the malfunction (Tab R-160 to R-161 and R-177). Troubleshooting is a vehicle maintenance skill and responsibility per AFI 24-302, *Vehicle Management*, paragraph 6.4 (Tab BB-124).

6. EQUIPMENT, VEHICLES, FACILITIES, AND SYSTEMS

The MV is a 2013 Polaris Ranger Model 800 Crew® all-terrain utility vehicle (Polaris), vehicle identification number (VIN) 4XAWH76A8D2707361 (Tab S-3). The owning organization was a unit of the 2nd Battalion/104th Aviation Regiment, WVARNG, deployed at the time of the mishap

in the USCENTCOM AOR as a component of Task Force Anvil (TF ANVIL) (Tabs D-3, D-19, Z-17, CC-109, CC-141, and EE-9). The vehicle was shipped from the aerial port of embarkation (APOE) at Robert Gray Army Air Field (AAF), West Fort Hood, Texas, on 12 September 2020 (Tabs K-3, D-19, and Z-17). The MV was aboard a C-17 Globemaster III aircraft ("C-17") with the call sign REACH 815, a United States Transportation Command (USTRANSCOM) mission (Tab K-3 and K-5). The C-17 arrived without incident at ASAB, the aerial port of debarkation (APOD), on 13 September 2020 (Tab K-3). The MV was unloaded from the aircraft by the 386 ELRS Ramp Section at approximately 2014L that same day and was later terminally parked in Bay 69 by the MVO (Tabs K-3, Tab R-160 to R-161, and R-175). At the time of the mishap, the MV displayed 3,227 miles on the odometer (Tab S-15).

a. Documents and Forms

As a USA vehicle, the MV was not required to carry the same documentation prescribed for United States Air Force (USAF) vehicles of this type (Tab EE-9). Additionally, at the time of the mishap, the MV had not been "dispatched" to any USA unit, which would have initiated a separate requirement for vehicle documentation (Tab EE-9). However, the following documents were found to be present in the dashboard storage compartment at the time of the mishap:

(1) Polaris Owner and Operator Manual, 100 pages (Tab BB-127 to BB-133).
(2) Polaris Certificate of Pre-Delivery Inspection (blank and undated), 1 page (Tab D-17).
(3) Invoice for Maintenance and Repair on MV from Commercial Vendor, dated 28 January 2020, 3 pages (Tab P-5 to P- 7).
(4) Shipper's Declaration for Dangerous Goods, dated [sic] 20 September 2020, 1 page (Tab D-19).
(5) Department of Defense Form 2977 (DD 2977), Deliberate Risk Assessment Worksheet, dated 11 June 2020, approved by TF ANVIL Brigade Commander, USA, 15 pages (Tab D-3 to D-15).

Figure 14 – MV Identification and Shipping Label (Tab Z-17)

Additionally, the following markings and identification plates were affixed to or displayed on the vehicle:

Figure 15 – MV Unit Identification Markings (Tab Z-19)

Figure 16 – MV Vehicle Identification Number (VIN) Plate (Tab S-3)

b. Scheduled Inspections

No documentation or evidence of inspections were present on the MV. At the time of the mishap, the MV was not "dispatched" to a USA, thus there was no requirement for inspection documentation (Tab EE-9).

c. Maintenance Procedures

An invoice for routine maintenance and repair work from a commercial vendor, Marietta Polaris located in Marietta, Ohio, was stored in the MV at the time of the mishap (Tab P-5 to P-7). Marietta Polaris was listed as an authorized Polaris dealer and maintenance and repair facility (Tab P-5). The invoice indicated that "full service" had been performed from 28 January 2020 to 12 February 2020 (Tab P-7). This service included lubrication, oil change, and filter replacement, as well as a replacement of "seat bottoms" and a "grommet" (Tab P-5).

d. Unscheduled Maintenance

No documentation or evidence of unscheduled maintenance was present on the MV to determine if the prescribed maintenance had been completed. The cumulative mileage for the MV listed on the invoice in February 2020 was 2,977 miles (Tab P-5). At the time of the 14 September 2020, the MV had accumulated an additional 250 miles (3,277 miles total) and seven (7) months had passed since the previously documented service (Tab S-15). According to the original equipment manufacturer (OEM) maintenance schedule, additional maintenance would have been required at fifty (50) operating hours or six (6) months' time (Tab BB-132 to BB-133).

e. Maintenance Personnel and Supervision

With the exception of the February 2020 invoice from Marietta Polaris, the MV did not contain any record of maintenance personnel or respective supervision who may have performed maintenance on the MV (Tab P-5 to P-7).

f. Damage to Mishap Vehicle (MV)

The MV was inspected by the GAIB and concurred with the SIB that no damage other than cosmetic finish scratches were noted (Tabs P-3 and Z-21).

g. Condition of Facilities

(1) Terminating Cargo Yard

At the time of the mishap, 386 ELRS members indicated concerns over the Bay 69 surface area where the mishap took place (Tab V-8.24). Members stated the surface, composed completely of sand, typically had ruts and washouts due to the heavy seasonal rains received in the area (Tab V-2.24, V-3.22, and V-8.24). However, testimony from INV2, SF2, SF5, and SF7, all of whom were Security Forces members that responded to the mishap scene, stated there was no evidence of surface erosion or other objects that may have impeded the path of the MV on the date of the mishap (Tab V-19.4, V-20.4, V-24.10, and V-27.5). Photographs taken at the time of the mishap did not indicate an unusually rough driving surface (Tab S-5, S-11, and S-19).

Subsequent to this mishap, the installation Civil Engineering Squadron (CES) "graded" the surface of Bay 69 to improve its condition (Tab V-1.14, V-7.26 and V-8.24 to V-8.25). This was accomplished by removing vehicles and cargo containers from the yard and leveling out the sand across the entire lot (Tab V-8.25). As a result, the GAIB was not able to examine the conditions of the surface that existed at the time of the mishap.

(2) Other Facilities

No other facilities or physical work centers were relevant to the mishap.

7. ENVIRONMENTAL CONDITIONS.

Kuwait is located at the northwestern corner of the Persian Gulf, sharing a southern border with Saudi Arabia and a northern border with Iraq, with the Persian Gulf to its east (Tab CC-36).

ASAB is situated approximately 35 miles west of Kuwait City (Tab CC-36). ASAB carries the International Civil Aeronautical Organization (ICAO) designation of OKAS (Tabs F-3 and CC-137). Field elevation is 472 feet (114 meters) above mean sea level (MSL) (Tab CC-137).

On the day of the mishap, two (2) observations were recorded:

At 1558L, approximately one (1) hour before the mishap, the ambient temperature was 114° F (46° C) with winds blowing from the southwest at 11.5 mph (Tabs F-3 and W-4). Clouds were

lightly scattered at 20,000 feet altitude and visibility was unlimited (Tabs F-3 and W-4). The dew point was 26° F and altimeter reading was 29.62 inches of mercury (in Hg) (Tabs F-3 and W-4).

At 1658L, the approximate time of the mishap, the ambient temperature was 113° F (45° C) and winds were blowing in from the southwest at 8 mph (Tabs F-3 and W-4). Visibility remained unlimited with lightly scattered clouds at 20,000 feet altitude (Tabs F-3 and W-4). The dew point was 26° F and altimeter reading was 29.63 inches of mercury (in Hg) (Tabs F-3 and W-4).

These observed conditions are normal for this location and season and there is no evidence to indicate weather conditions had any effect on the mishap (Tab CC-139).

8. PERSONNEL QUALIFICATIONS

a. Mishap Airman (MA)

The MA's initial date of service was 10 October 2014 (Tab T-3). Following basic military training, the MA would have attended Air Force Specialty Code (AFSC) 2T231, Air Transportation ("3-Level") technical training; however, his records did not indicate his dates of attendance. He did, however, enter into upgrade training to AFSC 2T251 ("5-Level") on 24 January 2016 (Tab T-18). He served in the category of traditional drilling reservist (Tab T-4 and T-15 to T-18).

The MA completed his on-the-job training (OJT) and specialty training in accordance with the Air Transportation (2T251) Career Field Education and Training Plan (CFETP) and was recommended for upgrade to AFSC 2T251 on 6 August 2017 (Tab T-17). Training records indicate the MA completed his final Career Development Course (CDC) test for AFSC 2T271 ("7-Level") on 6 October 2019, but recommendation for upgrade was not listed in the MA's Training Business Area (TBA) automated records (Tab T-15). TBA is the career field's computer based system for storing training records (Tab V-14.25). The MA completed Hazardous Materials Airlift Inspector training in February 2020 (Tab T-23).

Typical of Airmen serving in his specialty, the MA was trained, certified, and licensed to operate the following equipment and vehicles:

(1) Four thousand pound capacity (4K) forklift
(2) Six thousand pound capacity (6K) forklift
(3) Ten-thousand pound capacity (10K) standard forklift
(4) 10K all-terrain (AT) forklift
(5) Twenty-five thousand pound capacity aircraft loader ("Halvorsen")
(6) 29-passenger school bus
(7) 42-passenger school bus
(8) 15-passenger carryall van
(9) Aircraft lavatory service truck
(10) C-5 aircraft staircase truck
(11) Baggage conveyor belt vehicle
(12) Half-ton 4-wheel drive pickup truck
(13) Hi-Lift aircraft servicing truck

(14) Generic staircase truck (Tabs T-21 and V-7.21 to V-7.22).

There is no licensing required to operate a vehicle of the type involved in the mishap, thus it did not appear on the list of vehicles for which the MA was licensed (Tabs T-21 and V-7.35). A Polaris and similar type vehicles ("non-tactical vehicles where gross vehicle weight rating (GVWR) is less than 26,000 pounds") may be operated by Airmen with a state-issued driver's license (Tab BB-140). 386 ELRS A-Flight supervisors verified that the MA was trained and licensed to operate vehicles appropriate for his assigned duties by reviewing his AF Form 2293, *U.S. Air Force Motor Vehicle Operator Identification Card* (Tab V-8.12 and V-8.20). No records of the MA's Air Force license or state-issued driver's license were kept on site (Tab V-8.21).

No deficiencies were noted in the MA's training or military personnel records.

b. Mishap Vehicle Operator (MVO)

The MVO's initial date of service was 7 July 2015 (Tab T-25). His current date of completion of obligation of military service (DOS) is 6 July 2021 (Tab T-25). The MVO entered technical training to be an Air Transportation Apprentice ("3-Level") on 28 October 2015 (Tab T-26). The MVO completed initial technical training and reported for duty with qualification in AFSC 2T231 at the 437 APS, Joint Base Charleston, South Carolina, on 30 December 2015 (Tab T-25).

The MVO completed his on-the-job training (OJT) and specialty training in accordance with the 2T2X1 CFETP and was recommended for upgrade to 2T251 ("5-Level") on 8 February 2017 (Tab G-18). The MVO's training to 2T251 was paused from 22 June 2016 to 1 October 2016 and again from 4 January 2017 for approximately three (3) months while he served outside of his core specialty on the Base Honor Guard (Tabs G-18 to G-19 and T-31). His training was paused once again when he also served outside of his core specialty while serving as a First Term Airman Course (FTAC) instructor for 100 days in 2019 and 2020 (Tabs G-15 and T-29). The MVO was current on all upgrade training (Tab T-37 to T-38).

Typical of Airmen serving in his specialty, the MVO was trained, certified, and licensed to operate the following equipment and vehicles:

(1) Four thousand pound capacity (4K) forklift
(2) Ten-thousand pound capacity (10K) standard forklift
(3) 10K all-terrain (AT) forklift
(4) Twenty-five thousand pound capacity aircraft loader ("Halvorsen")
(5) 15-passenger carryall van (Tabs G-3 and V-7.21 to V-7.22).

There is no licensing required to operate a vehicle of the type involved in the mishap, thus it did not appear on the list of vehicles for which the MVO was licensed (Tabs G-3 and V-7.35). A Polaris and similar type vehicles ("non-tactical vehicles where gross vehicle weight rating (GVWR) is less than 26,000 pounds") may be operated by Airmen with a state-issued driver's license (Tab BB-140). 386 ELRS A-Flight supervisors verified that the MVO was trained and licensed to operate vehicles appropriate for his assigned duties by reviewing his AF Form 2293 (Tab V-8.12 and V-8.20). No records of the MVO's Air Force license or state-issued driver's license were kept on site (Tab V-8.21).

The MVO was previously deployed to Al Udeid Air Base, Qatar, for six (6) months in 2017 and also served in the Cargo and Special Handling sections (Tabs R-148, R-179, and T-33). No deficiencies were noted in the MVO's training or military personnel records.

9. MEDICAL

a. Qualifications

There are no relevant medical qualifications required for duties related to the mishap.

b. Health

(1) Mishap Airman's (MA's) Health

There is no evidence in the medical history to suggest that the MA's physical or mental health had any bearing on the mishap or the outcome of the mishap (Tab DD-7 to DD-8). The MA had not been seen or treated for any concerns prior to the mishap (Tab DD-7).

The MA had no documented history of prescription medication, over-the-counter (OTC) medication, supplement, or substance abuse (Tab DD-7). There is no evidence to suggest that lifestyle factors contributed to the mishap or the outcome of the mishap (Tab DD-7).

(2) Mishap Vehicle Operator's (MVO's) Health

There is no evidence in the medical history to suggest that the MVO's physical or mental health had any bearing on the mishap (Tab DD-7). The MVO had not been seen or treated for any concerns prior to the mishap (Tab DD-7).

The MVO denied use of prescription medications, OTC medications, supplements, or substance use surrounding the incident (Tab DD-7). There is no evidence to suggest that lifestyle factors contributed to the mishap (Tab DD-7).

c. Post-Mishap Medical Findings

(1) Medical Examiner Report

The autopsy was performed at 0730 hours Eastern Daylight Time (EDT), on Saturday, 19 September 2020, by a medical examiner from the Armed Forces Medical Examiner Office (OAFME), Defense Health Agency (DHA), Dover AFB, Delaware (Tab DD-7 to DD-8). The MA was positively identified using ante-mortem fingerprint and dental record comparisons (Tab DD-7 to DD-8).

The MA was noted to have evidence of severe trauma to the head, which was documented as the cause of death (Tab DD-8). The MA had other non-serious traumatic injuries, including scrapes on his chest, back, and arms (Tab DD-8). Based on autopsy findings, there was no evidence of

underlying medical conditions that might have contributed to the outcome of the mishap (Tab DD-8).

(2) Clinic Evaluation

The MVO was examined after the incident and treated in the clinic for minor scrapes on his arm and a bruise on his right hip from wearing his LMR (Tabs R-166 and DD-7). There were no findings that would be considered relevant to the cause or the outcome of the mishap (Tab DD-7).

No other parties sustained injury in the mishap (Tabs B-3 to B-4 and DD-7 to DD-8).

d. Toxicology Analysis

(1) Mishap Airman (MA)

At the time of the autopsy, the MA had negative toxicology testing for drugs of abuse, medications, and ethanol (Tab DD-8).

(2) Mishap Vehicle Operator (MVO)

On the day of the mishap, the MVO's blood and urine toxicology screen were negative for drugs of abuse, medications, and ethanol (Tab DD-7).

10. OPERATIONS AND SUPERVISION

a. Operations

The MA and MVO were assigned to the Special Handling Section of the 386 ELRS (Tabs R-148 and R-158). The squadron and subordinate echelons conduct 24-hour daily operations in support of the flying missions of the 386 AEW (Tabs R-6, R-154, CC-9, CC-18, and CC-21). This includes providing APOE and APOD cargo preparation, inspection, loading, and unloading operations from aircraft (Tab CC-21 and CC-23).

Personnel assigned to the Special Handling Section work twelve (12) hour daily shifts, six (6) days per week, with one (1) scheduled off-duty day (Tab R-77, R-80, and R-150). This is typical of work shift assignments across the 386 ELRS and elsewhere in the 386 AEW (Tabs R-77, R-80, R-150, and V-8.9). Typical duty days consist of intermittent, high-tempo operations in support of arriving and departing cargo aircraft (Tabs R-150 and V-13.22). Specific tasks include JI of cargo destined for loading onto aircraft, managing off-loaded palletized cargo and containers, managing rolling stock (e.g. vehicles and wheeled equipment), and managing in-transit inventory of these special cargo items awaiting customer pickup or other disposition (Tab BB-18).

During the intervening time between cargo operations and other assigned administrative tasks, Special Handling personnel are afforded time for meals, breaks, and social and recreational activities within their respective and adjacent work centers (Tab V-7.32). In some cases, off-duty personnel visited the work center to socialize, as it was deemed a more comfortable location than other available areas on the installation (Tab V-7.32). According to 386 ELRS members,

operational tempo in the Special Handling Section did not outpace the ability of assigned personnel to perform the mission (Tabs R-150, V-13.22 to V-13.24, V-13.31, V-14.22 to V-14.24, V-15.15, and V-15.23).

b. Supervision

(1) Organizational Structure

A-Flight of the 386 ELRS was supervised by SUP3 (a Captain, O-3), a Chief Master Sergeant (E-9), and SUP4 (a Senior Master Sergeant, E-8) (Tab V-3.1, V-4.5, and V-5.1). The Special Handling Section, one of four (4) sections within A-Flight, was staffed by enlisted personnel from grades E-4 (Senior Airman) to E-7 (Master Sergeant), all possessing the Air Transportation AFSC 2T231 ("3-Level"), 2T251 ("5-Level"), or 2T271 ("7-Level") (Tab V-7.2, V-10.1 to V-10.2, V-13.2, and V-15.2). The Special Handling Section Chief, SUP2, was a Master Sergeant with AFSC 2T271 ("7-Level") (Tabs R-154 and V-7.2). Duty shifts of supervisory personnel were staggered from the duty shifts of section personnel, with the Flight Chief working from 0600L to 1800L while the section personnel worked from either 0000L to 1200L or 1200L to 0000L (Tab R-6, R-154, and R-164).

(2) Assignment of Work Duties

Work assignments for the Special Handing Section were typically assigned at either the beginning of a duty shift or later in the shift and were largely dependent upon the schedule of inbound and outbound cargo aircraft missions (Tabs R-153, V-2.19, V-7.23, and V-8.20). Work was assigned by either SUP1 or SUP2 and any changes to those assigned duties were communicated either by a supervisor or the Special Handling dispatcher (Tabs R-154, V-2.19, V-8.20, and V-15.3).

On the day of the mishap, the MA was assigned as the Special Handling dispatcher, and the MVO was assigned to inspect cargo prior to it being loaded onto aircraft (Tabs R-74, R-155, and V-7.23 to V-7.25) The MVO was also assigned to load and unload cargo and rolling stock from the aircraft (Tab R-157 to R-159). The MVO downloaded the Jeep and the wrecker from a C-17 aircraft (Tabs R-157 to R-159). The day prior to the mishap, 13 September 2020, the MVO downloaded the MV from a separate C-17 aircraft (Tab R-175 to R-176).

(3) Oversight of Cargo and Equipment

Work centers assigned to the 386 ELRS span the entirety of ASAB, with functions situated in the main operating and living area of the base, known locally as "The Rock," as well as adjacent to the flight line in restricted areas known as "The Quarry" (Tabs CC-27, R-5, R-16, R-31, V-1.19, and V-15.25). The Command Section of the 386 ELRS is situated in Building 2008, inside the flight line restricted area and across from ECP 5 (Tab R-16, R-37 to R-38, and R-64). The A-Flight supervision office in Building 2035 and the Special Handling Office in Building 2034 are situated approximately 150 yards from the ELRS Command Section and are well within its view (Tabs R-62, V-2.2, and V-21.10). Similarly, the cargo yards known as W Pad and Bay 69 are within 200 yards of the Command Section and are both within view of leadership (Tab V-2.2 and V-4.2).

The location of all inbound and outbound cargo controlled by the ELRS and A-Flight is required to be tracked and documented (Tabs V-7.27 and BB-12). Specific types of high-value and hazardous cargo items are required to be secured and under surveillance to preclude damage, theft, pilferage, or misuse (Tabs V-7.27 and BB-12). As the name of the section implies, these types of cargo are the responsibility of the Special Handling Section and include the terminating cargo yard, Bay 69 (Tabs V-7.30, BB-12, and BB-18). Testimony as to whether the yard was locked and under surveillance conflicted among supervision (Tabs R-18 and V-7.27). While Bay 69 is located inside a fenced and gated area belonging to the Special Handling dispatch section, it was never observed to be closed or locked during the four (4) weeks that the GAIB was on-scene to conduct its investigation (Tab Z-25).

Figure 17 – 386 ELRS Office Buildings (Tab Z-23)

11. GOVERNING DIRECTIVES AND PUBLICATIONS

a. Publicly Available Directives and Publications Relevant to the Mishap

(1) AFI 13-213, *Airfield Driving*, 4 February 2020

(2) AFI 20-112, *Logistics Readiness Quality Assurance (LR QA),* 6 October 2017

(3) AFI 24-301, *Ground Transportation*, 22 October 2019

(4) AFI 24-302, *Vehicle Management*, 21 February 2020

(5) AFMAN 24-306, *Operation of Air Force Government Motor Vehicles*, 30 July 2020

(6) AFI 24-605 Vol. 1, *Air Transportation Organization and Structure*, 2 July 2020

(7) AFI 24-605 Vol. 2, *Air Transportation Operations*, 2 July 2020

(8) AFI 24-605 Vol. 3, *Air Transportation Functions and Unilateral Aircrew Training*, 2 July 2020

(9) AFI 24-605 Vol. 4, *Air Transportation Reserve Components*, 2 July 2020

(10) AFI 24-605 Vol. 5, *Air Transportation Standardization and Resources*, 2 July 2020

(11) 386 AEW Instruction (AEWI) 31-218, *Motor Vehicle Traffic Supervision*, 26 August 2019

(12) AFI 51-307, *Aerospace and Ground Accident Investigations*, 18 March 2019

(13) AFI 90-201, *The Air Force Inspection System*, 20 November 2018

(14) AFI 90-802, *Risk Management*, 1 April 2019

(15) AFPAM 90-803, *Risk Management (RM) Guidance and Tools*, 11 February 2013

(16) AFI 91-202, *The USAF Mishap Prevention Program*, 12 March 2020

(17) AFI 91-207, *The U.S. Air Force Traffic Safety Program*, 26 July 2019

(18) DoDM 4500.36, *Acquisition, Management, and Use of DoD Non-Tactical Vehicles*, 7 July 2015

(19) DoDI 6055.04, *DoD Traffic Safety Program*, 20 April 1999

NOTICE: All directives and publications listed above are available digitally on the Air Force Departmental Publishing Office website at: https://www.e-publishing.af.mil or on the Executive Services Directorate website at: https://www.esd.whs.mil/DD/DoD-Issuances/.

b. Other Directives and Publications Relevant to the Mishap

(1) 2013 Polaris Owner's Manual for Maintenance and Operation

(2) AFCENT Aerial Port (AP) Letter of Instruction (LOI), January 19_IMC 3 (Mar 20)

(3) DTR 4500.9-R Part III, *Mobility*, 10 July 2020

c. Known or Suspected Deviations from Directives or Publications

(1) Risk Management and Safety Procedures Briefing

In accordance with AFI 90-802, *Risk Management*, "Risk Management (RM) is a decision-making process to systemically evaluate possible courses of action, identify risks and benefits, and

determine the best courses of action for any given situation" (Tab BB-136). RM involves four (4) main principles, including (1) accept no unnecessary risk, (2) make risk decisions at the appropriate level, (3) integrate RM into operations and activities at all levels, and (4) apply the process both cyclically and continuously (Tab BB-138). RM takes into consideration that risk is inherent in all missions, operations, and activities, both on and off-duty, and RM principles are applicable 24 hours a day, 7 days a week, and 365 days a year (Tab BB-138). All Air Force personnel are required to utilize sound RM principles, processes, tools, and techniques to assess and mitigate risks and promote proactive mishap prevention associated with all activities both on and off-duty *(*Tab BB-137).

In accordance with AFMAN 24-306, *Operation of Air Force Government Motor Vehicles,* paragraph 7.13, the operator of a motor vehicle is required to first check the vehicle's manufacturer's operator's manual before operating the vehicle (Tab BB-143). The MVO acted inconsistent with the MV's Owner's Manual, as well as violated multiple Air Force and Department of Defense Traffic Safety Regulations, when he failed to take the necessary precautions while attempting a sharp turn (180 degrees) at a high rate of speed (approximately 25-35 mph) on the sand surface, while operating the MV for a non-mission related purpose (Tabs O-13, O-15, V-1.13 to V-1.14, V-21.4, V-21.6, V-21.15, V-23.4, V-24.10, V-25.4, BB-46, BB-50, BB-128 to BB-131, BB-141, and BB-145 to BB-146). Additionally, both the MVO and MA deviated from Air Force policy outlined in AFMAN 24-306, paragraph 4.2.5, and 386 AEWI, paragraph 5.4, by failing to wear the required available seatbelts, the requisite personal protective equipment (PPE), and the proper clothing (Tabs R-140, R-165, V-21.6, V-28.3, BB-50, BB-141, and DD-9).

In accordance with 386 AEWI 31-218, the local wing traffic safety instruction, published in August 2019, all unit commanders are required to "promote an educational program on the contents of this instruction and provide sufficient copies to all respective areas within their command and control" (Tab BB-34). This instruction discusses driving privileges on ASAB and other "rules of the road" (Tab BB-29 to BB-56). It specifically discusses requirements for operation of Other Government Motorized Vehicle Conveyances (OGMVC), with the requirements for the Polaris Ranger specifically spelled out (Tab BB-50). Helmets, eye protection, and long sleeves are required to be worn while riding in or operating a Polaris Ranger (Tab BB-50). Unit leadership reported that all members of the 386 ELRS receive a Safety Briefing in accordance with this instruction immediately upon arrival to ASAB (locally known as the "Rock-In" Briefing) (Tabs R-13, V-2.11, V-3.7 to V-3.8, V-3.10 to V-3.11, V-15.10, and CC-27 to CC-90). However, of the twelve (12) ELRS members asked by the GAIB, none were aware of these requirements for the Polaris Ranger, including leadership (Tab V-1.12, V-2.16 to V-2.17, V-2.20, V-3.13, V-3.21, V-4.20, V-6.9, V-7.25 to V-7.26, V-7.36 to V-7.37, V-8.11, V-8.24, V-11.9, V-13.17, V-14.20, and V-15.11). Leadership also stated the manner in which the briefing is conducted (as the members are getting off the bus at all hours of the day and night) is probably not the most conducive manner for retention of information (Tab V-7.13). No records or documentation were kept reflecting actual attendance or completion of the safety briefing by 386 ELRS members, including the MA and MVO (Tab EE-5).

(2) Seat Belts and PPE

In accordance with AFI 91-207, *The U.S. Air Force Traffic Safety Program*, seatbelts must be worn by all operators and passengers of U.S. government vehicles on U.S. installations at all times (Tab BB-150). The operator of the government motor vehicle is responsible for ensuring the safety and comfort of all passengers, which includes ensuring that seat and shoulder belts are safely fastened prior to putting the vehicle in motion (Tab BB-141 and BB-150). The requirement for a seatbelt is also stated in the Polaris Owner's Manual eleven (11) different times (Tab BB-127 to BB-131).

Figure 18 – MV Post-Mishap with All Shoulder Straps Securely Fastened (Tab Z-27)

Both the MVO and the MA violated these regulations when they failed to wear their seatbelts (Tabs R-165, V-21.6, V-28.3, and DD-9). During inspection of the MV, the GAIB tested the seat belts to determine whether or not they were in working condition. Despite slight fraying in several locations on the seat belts, the GAIB was able to securely fasten all four (4) shoulder seatbelts on the MV (Tab Z-27 and Z-29). The Polaris Owner's Manual also states that "riding in this vehicle without using the cab nets increases the risk of serious injury or death in the event of an accident or overturn. Always use cab nets while riding in this vehicle." (Tab BB-131). There were no cab nets installed on the MV at the time of the mishap (Tab S-19).

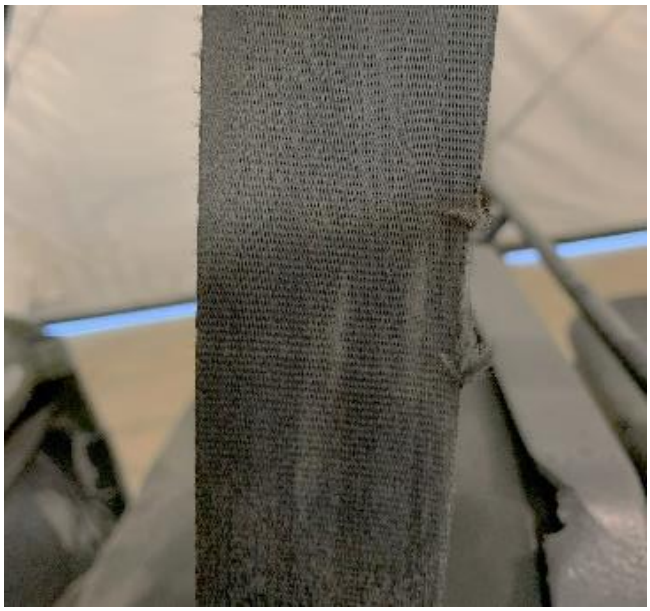

Figure 19 – Fraying on MV Seatbelt (Tab Z-29)

Additionally, in accordance with both 386 AEWI 31-218 and the Polaris Owner's Manual, helmets are required while operating or riding in this type of motor vehicle (Tab BB-50 and BB-129). However, only one (1)

member interviewed by the GAIB was aware of this requirement (Tab V-1.12). While the Polaris Owner's Manual requires a U.S. Department of Transportation (DOT) approved helmet, the local wing instruction allows for a DOT-approved helmet or a ballistic helmet (Tab BB-50 and B-129). Both publications also require the wear of eye protection (shatter proof safety goggles or a face shield) and a long sleeve shirt with the sleeves rolled down (Tab BB-50 and BB-129). There is no evidence to support that either the MVO or the MA were wearing a helmet or eye protection at the time of the mishap (Tab DD-9). The MA was wearing a short sleeved shirt and the location of the scratches on the MVO's arms are consistent with the MVO not wearing long sleeves (Tabs R-166 and DD-9).

(3) Speed Limit

In accordance with 386 AEWI 31-218, the speed limit on ASAB is 12 mph unless otherwise posted (Tab BB-46). In and around the 386 ELRS facilities, including W Pad, the posted speed limit is 5 mph (Tab Z-13 and Z-15). The Polaris Owner's Manual states operators should "never operate at excessive speeds. Always travel at a speed proper for the terrain, visibility and operating conditions, and your experience" (Tab BB-130). Additionally, the Owner's Manual states "always follow proper procedures for turning. Practice turning at slow speeds before attempting to turn at faster speeds. Never turn at excessive speeds" (Tab BB-130). The Owner's Manual also warns operators to "avoid sharp turns or turns while applying heavy throttle" (Tab BB-128). Lastly, operators should "reduce speed and use extreme caution when carrying passengers" (Tab BB-128). 386 AEWI 31-218 states the maximum speed limit for an OGMVC (i.e. a Polaris Ranger) is 25 mph, however, "drivers will obey all speed limits indicated in this instruction" (Tab BB-50). While calculations made by INV2 estimated the MV was traveling at a speed between 25 and 35 mph, the MVO also indicated he was traveling too fast for the turn and the terrain (Tabs O-13, O-15, R-139, V-24.5, V-24.10, V-24.18, and V-29.4).

(4) Aerial Port Members Performing Vehicle Maintenance

A standard inspection of a vehicle prior to use is required to be performed and documented on AF Form 1800 (Tab BB-142). If issues arise with vehicle operation and the defects exceed the operator's responsibility, individuals are required to enter the details on the AF Form 1800 and take the vehicle to the Vehicle Management Customer Service Center for corrective action (Tab BB-142.) When vehicles are transported downrange, the deploying unit is responsible for providing minor maintenance to the transported vehicles (Tab BB-122).

The MVO violated regulation when he took it upon himself to fix the "sputtering" on the MV, which he was not authorized to do (Tab R-160 to R-162). According to testimony provided to the SIB, the MVO attempted to drive the MV on the day prior to the mishap, 13 September 2020, and on the day of the mishap, 14 September 2020, in order to determine the cause of the deficiency (Tab R-160 to R-162, and R-191). The MVO testified that this was the reason he was in the MV with the MA on the day of the mishap, however, his statements to first responders within minutes of the accidents were that he and the MA were just "joy-riding" (Tab R-160 and R-191). Whether troubleshooting the MV or joy-riding, every member of the 386 ELRS that was interviewed by the GAIB stated this type of action would be inappropriate and maintenance would not be the responsibility of A-Flight members (Tabs R-106, V-2.18 to V-2.20, V-4.15, V-8.20, and V-15.22

to V-15.23). ELRS members also noted, leadership included, that the vehicle should have been turned into Vehicle Maintenance for troubleshooting per standard operating procedures (Tab V-2.20, V-7.16 to V-7.17, V-7.20 to V-7.21, and V-15.22).

(5) Post-Mishap Administrative Actions

(a) Required Forms

Neither the first responders nor MVO's supervision ensured the completion of required forms following the mishap. The required Standard Form 91, *Motor Vehicle Accident Report*, AF Form 978, *Supervisor Mishap Report*, and Standard Form 94, *Statement of* Witness were not properly completed. After an on-base accident, "the vehicle operator should remain at the accident site until released by Security Forces" (Tab BB-51). The operator will complete the Standard Form 91, *Motor Vehicle Accident Report*, as soon as possible, but no later than 24 hours after release by Security Forces. This form must be submitted to Vehicle Management in Bldg. 650" (Tab BB-52). The operator's supervisor will ensure the AF Form 978, *Supervisor Mishap Report*, is completed and turned into the Wing Safety Office no later than three (3) days after the incident (Tab BB-52). A USCENTCOM Aerial Port Letter of Instruction (LOI) dated 1 January 2019 allows these forms to be turned in within four (4) days and The Rock-In Briefing indicates a 5-day reporting requirement (Tabs BB-107 and Tab CC-54). "If involved in a GMV accident, an operator surrenders the AF Form 2293 (government license), with the SF [Standard Form] 91 and SF [Standard Form] 94, *Statement of Witness*, to the Unit Vehicle Control Official" (Tab BB-152). Unit commanders may return the AF Form 2293 at their discretion (Tab BB-152).

While it is not clear who released the MVO from the mishap scene in order for him to be transported to the clinic, INV1 was unable to speak with the MVO before he left the scene (Tab V-21.6 and V-21.10). Additionally, due to the MVO's departure from the AOR shortly after the mishap, INV1 was not able to interview the MVO prior to his re-deployment back to home station (Tab V-21.8). Neither a Standard Form 91 nor an AF Form 978 were filed after the mishap (Tab V-2.21, V-3.18 to V-3.19, and V-8.34).

(b) Misuse of Government Vehicles

In accordance with Department of Defense Manual 4500.36, *Acquisition, Management, and Use of DoD Non-Tactical* Vehicles, the use of all DoD motor vehicles will be restricted to official purposes only (Tab BB-154). Determination of whether a particular use is for an official purpose is a matter of administrative discretion to be exercised within applicable law and regulations and includes whether the transportation is essential to the successful completion of a DoD function, activity, or operation and whether it is consistent with the purpose for which the vehicle was acquired (Tab BB-154).

The MVO provided testimony to the SIB that he was aware the MV was not an ELRS asset assigned to the Special Handling Flight and that instead it was a piece of cargo (Tab R-162). Through testimony provided to the GAIB, leadership demonstrated knowledge of the events that took place during the mishap, including that the MVO and MA were "messing around" with the MV and that they were likely traveling at a high rate of speed (Tab V-1.13 to V-1.14).

Additionally, the MVO stated he was not trained as a mechanic and had no obligation in regards to the MV other than to terminally park it in the cargo yard (Tab R-193). Since the operation of the MV was not essential to the successful completion of a DoD function, activity, or operation and was not consistent with the purpose for which it was acquired, the driving of the MV by the MVO would not have been for official purposes and would have been considered misuse of the MV.

[redacted]

26 FEBRUARY 2021

MAX J. STITZER
Brigadier General, USAF
President, Ground Accident Investigation Board

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