

# GCE/LCE Lessons Learned

## Safety Division

### Fatal Motorcycle Mishap (Background and Situation)

While PTAD for home town recruiting assistance, SNM purchased a sport bike from the station SNCOIC.

SNM purchased the bike on the 28<sup>th</sup> day of 30 day PTAD.

Before returning from PTAD, SNM met up with his friends with the newly purchased (unregistered, unlicenced, uninsured) motorcycle at a gas station that was a popular gathering point for riders.

Upon departing the area, things turned horribly wrong... SNM accelerated at a high rate of speed leaving, what local police reports stated, a 140 foot burnout. SNM lost control of the motorcycle and drove into a steel beam, catapulting SNM into a store window...causing fatal injuries.

SNM's helmet was not strapped to the head and was cracked completely through. SNM's shoes ('Chuck Taylors') were untied and ended up in two different resting spots.

SNM did not receive any approved training at all.

The father of this Marine was the responding EMT to the crash site...





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### Fatal Motorcycle Mishap (Causal Factors)

#### **Human Factors:**

- (1) (Victim): SNM failed to attend formal required training and was not licensed or registered to ride on the street.
- (2) (Victim): SMN purchased a motorcycle that greatly superseded riding ability.
- (3) (Victim): SNM failed to wear approved PPE per MCO 5100.19F and did not have an updated Drive Safe Packet.
- (4) (Victim): SNM failed to conduct a proper pre-ride motorcycle inspection; bike needed new tires which may have contributed to the mishap.
- (5) (Victim): SNM failed to inform command of the change in riding status.
- (6) (Victim): SNM operated the motorcycle in a reckless and unsafe manner.

#### **Supervision**:

- (1) (SNCOIC): The station SNCOIC should have informed the SNM of the requirements of MCO 5100.19 and of state and local laws regarding licensing and registration; then discussed the plans of the SNM to meet these requirements.
- (2) (Unit): Unit failed to ensure all drive safe packets were up to date and failed to discuss MCO 5100.19 as part of the unit check in process.
- (3) (Unit): Unit routinely failed to ensure riders attended all required training. (3 days of training -level 1& II- could have prevented this loss)



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### Fatal Motorcycle Mishap (Lessons Learned)

## This mishap did not have to occur!

SNM chose to ride recklessly; chose to not get trained; chose not to notify the command; chose not to wear the proper gear; chose not to license or register the vehicle; chose not to do the right thing!

### Make better choices!!

#### **Recommendations:**

- Unit should conduct periodic drive safe packet updates and challenge leadership at all levels to become more actively engaged in monitoring unit ridership.
- (2) Unit should establish a check-in process that ensures all personnel are aware of the requirements associated with operating a motorcycle in accordance with MCO 5100.19.
- (3) Refocus the unit Motorcycle Mentorship Program (MMP) to allow for a positive atmosphere for riders of all experience levels to improve riding skills and develop better decision making processes.



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