

UNITED STATES AIR FORCE
GROUND ACCIDENT INVESTIGATION
BOARD REPORT



**824TH SECURITY FORCES SQUADRON
93RD AIR GROUND OPERATIONS WING
MOODY AIR FORCE BASE, GEORGIA**

LOCATION: MOODY AIR FORCE BASE, GEORGIA

DATE OF ACCIDENT: 21 JANUARY 2010

BOARD PRESIDENT: COLONEL THOMAS M. WEBSTER

Conducted IAW Air Force Instruction 51-507

United States Air Force Ground Accident Investigation Board Report

On-Duty Fatality Moody Air Force Base, Georgia 21 January 2010

EXECUTIVE SUMMARY

On 21 January 2010, a 23-year-old active duty Senior Airman, Participant 1 (P1), of the 824th Security Forces Squadron (SFS), Moody Air Force Base (AFB), Georgia, collapsed and died while running as part of a practice Army Physical Fitness Test. There were no other injuries resulting from this mishap.

P1 was being timed on the two-mile run and collapsed after approximately 1.6 miles. Very shortly after he collapsed, a bystander who was driving by saw P1 lying in a prone position on the running track and stopped to assist. P1 was moaning and unable to get up, so the bystander immediately notified personnel in the air traffic control tower on base, who in turn notified emergency response personnel. Other personnel arrived on scene in less than 2 minutes. They observed that P1 was unresponsive and were unable to feel a pulse. They turned P1 over onto his back and confirmed he was not breathing and did not have a palpable pulse. They immediately began cardiopulmonary resuscitation (CPR). CPR was continued until the ambulance arrived 10 minutes later at approximately 0800L. The emergency medical responders took over CPR and attached a cardiac monitor to P1, which showed his heart rhythm was asystole. They followed the advanced cardiac life support protocol for asystole. P1 was placed onto the ambulance, which departed immediately for a hospital approximately 10 miles from the base. During transit CPR was continued, P1 was intubated without incident, and an intravenous line was established. P1 was given epinephrine and atropine. Despite the interventions, there was no change in P1's condition. The ambulance arrived at the hospital at 0827L. The emergency department specialists continued resuscitation efforts without result. A doctor from the admitting hospital declared P1 dead at 0852L.

The autopsy report determined P1 died from sudden cardiac death (SCD) likely caused by hypertrophic cardiomyopathy (an enlarged heart muscle) and a hypoplastic (underdeveloped) right coronary artery. Although hypertrophic cardiomyopathy can occur at any age, it is the most common finding associated with sudden cardiac death in young individuals. The second most common autopsy finding of young individuals who have died of SCD is an abnormal cardiac blood vessel. P1 had both conditions.

**SUMMARY OF FACTS AND STATEMENT OF OPINION
ON-DUTY FATALITY
MOODY AFB, GEORGIA
21 JANUARY 2010**

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COMMONLY USED ACRONYMS AND ABBREVIATIONS

ACC	Air Combat Command	FM	Fitness Monitor
ACLS	Advanced Cardiac Life Support	FSQ	Fitness Screening Questionnaire
AED	Automated External Defibrillator	GA	Georgia
AETC	Air Education and Training Command	GAIB	Ground Accident Investigation Board
AFB	Air Force Base	IV	Intravenous
AFI	Air Force Instruction	L	Local Time
AGOW	Air Ground Operations Wing	MEPS	Military Entrance Processing Station
AHA	American Heart Association	MDG	Medical Group
APFT	Army Physical Fitness Test	PA	Physician Assistant
ATC	Air Traffic Control Tower	PTL	Physical Training Leader
BLS	Basic Life Support	SABC	Self Aid and Buddy Care
COS	Combat Operations Squadron	SDC	Sudden Cardiac Death
CPR	Cardiopulmonary Resuscitation	SFG	Security Forces Group
EKG	Electrocardiogram	SFS	Security Forces Squadron
ED	Emergency Department	SGMC	South Georgia Medical Center
EMS	Emergency Medical Services	SRT	Special Reaction Team
EMT	Emergency Medical Technician	USAF	United States Air Force
ETT	Endotracheal Tube		

The above list was compiled from the Summary of Facts, the Index of Tabs, and Witness Testimony.

SUMMARY OF FACTS

1. AUTHORITY, PURPOSE, AND CIRCUMSTANCES

a. Authority

On 22 February 2010, Lieutenant General William J. Rew, Vice Commander, Air Combat Command (ACC), appointed Colonel Thomas M. Webster as Board President of a Ground Accident Investigation Board (GAIB) to investigate a mishap that occurred on 21 January 2010 involving a military member participating in a practice Army Physical Fitness Test (APFT) at Moody Air Force Base (AFB), Georgia (GA). (Tab X-3) Technical advisors were Lieutenant Colonel Mikelle A. Maddox (Medical), Captain Jason R. Smith (Legal Advisor), and Technical Sergeant Mark R. Cave (Recorder). (Tab X-3)

b. Purpose

The purpose of this investigation is to provide a publicly releasable report of the facts and circumstances surrounding the accident; to gather and preserve evidence for claims, litigation, disciplinary, and adverse administrative actions; and for other purposes. This report is available for public dissemination under the Freedom of Information Act.

c. Circumstances

The GAIB was convened to investigate the Class A mishap involving a member who was participating in a practice APFT on 21 January 2010 at Moody AFB. The investigation was conducted at Moody AFB from 3 March through 10 April 2010. The board dispersed awaiting the autopsy report. The autopsy report was received by the GAIB on 16 April 2010 and the report was finalized on 26 April 2010. (Tab W-3)

2. ACCIDENT SUMMARY

On 21 January 2010, at approximately 0748 local (L) Senior Airman Chad Rice, Participant 1 (P1), collapsed while participating in the two-mile running portion of a practice APFT. (Tab B-3) P1 collapsed after running approximately 1.6 miles. (Tab B-3) Very shortly after his collapse, a bystander who was driving by saw P1 lying on the ground and stopped to assist. (Tab V-1.1) P1 was not verbally responsive but made a moaning noise. This prompted the bystander to immediately notify personnel in the air traffic control tower on base, who have a direct line to all emergency responders on base. The tower notified the emergency response personnel. (Tab V-1.1) Other personnel arrived on scene in less than 2 minutes. (Tab V-1.1) They observed that P1 was unresponsive. (Tabs R-37, V-1.1) They were unable to feel a pulse, so they turned P1 over onto his back. (Tab R-37) At this time, they confirmed P1 was not breathing and did not have a palpable pulse. They immediately began cardiopulmonary resuscitation (CPR). (Tab R-37) CPR was continued until Emergency Medical Services (EMS) arrived on scene by ambulance at approximately 0800L. (Tab R-18, R-23, R-37) EMS providers took over the CPR

and attached an automatic external defibrillator (AED) to P1, which showed his heart to be in asystole (cardiac standstill). (Tab R-18) They followed Advanced Cardiac Life Support (ACLS) protocol asystole. (Tabs R-18, V-4.3, V-4.4) P1 was placed in the ambulance, which departed immediately for the Emergency Department (ED) at the South Georgia Medical Center (SGMC) approximately 10 miles from the base. (Tab R-21, R-23, V-4.3) During transit, CPR was continued, P1 was intubated without incident, and an intravenous line (IV) was established. (Tab R-23, V-2.1) P1 was given epinephrine and atropine. (Tab R-23) Despite the interventions there was no change in P1's condition. (Tab R-21, R-23) The ambulance arrived at the SGMC at 0827L. (Tab FF-3) The ED specialists continued resuscitation efforts without result. (Tab FF-4) A doctor at the SGMC declared P1 dead at 0852L. (Tab FF-6) There were no other injuries resulting from this mishap.

3. BACKGROUND

a. Relevant Units

P1 was permanently assigned to the 824 SFS, 93 AGOW, Moody AFB. (Tab B-1) The EMS responders who responded to the mishap were assigned to the 23d Medical Group (MDG), Moody AFB. (Tab C-3)



The 93 AGOW provides highly trained ground combat forces capable of integrating air and space power into the ground scheme of fire and maneuver. The wing also conducts offensive and defensive ground combat operations worldwide to protect expeditionary aerospace forces anywhere, anytime. The 93 AGOW provides the joint force commander airborne, air-mobile, air-land and over-land insertion capability, and remains the joint expert on integration of air power and combat weather support to ground forces. (Tab CC-3)



The mission of the 820th Security Forces Group (SFG) is to establish and conduct force protection operations on a global scale. They assess, prepare, and establish airfields through airborne, air-mobile, air-land, and over land insertion operations. The 820 SFG provides first in, highly capable, force protection and contingency response for expeditionary air forces anywhere, anytime, and under austere conditions. The 820 SFG staff and squadrons are composed of over 685 people in 26 functional career fields. It is the first Air Force unit designed specifically to provide fully integrated force protection. (Tab CC-6)



The 824 SFS provides fully-integrated, highly capable and responsive forces to protect Expeditionary Air Forces. (Tab CC-6)



SrA Chad Rice (P1) enlisted in the United States Air Force (USAF) on 23 January 2007. (Tab G-3) After completing basic military training at Lackland AFB, Texas, he reported to the 824 SFS at Moody AFB on 10 September 2007 and was assigned as a Fire Team Member. (Tab G-11) P1 was highly involved in physical activities and did not exhibit any physical limitations. (Tab R-35, V-4.4, V-4.6) Members from his unit observed him play basketball and football and lift weights. (Tab V-4.6) He deployed two times in support of Operation IRAQI FREEDOM. (Tab V-4.5) He was at Camp Bucca, Iraq, from January to July 2009 and in Balad, Iraq, from January to July 2008. (Tabs R-8, R-35, V-4.5)

b. Purpose of the Army Physical Fitness Test (APFT)

On 20 January 2010, P1 was selected to attend the Special Reaction Team (SRT) Course at Fort Leonard Wood, Missouri, which was scheduled to begin on 25 January 2010. (Tabs O-3, R-11, R-12) Air Education and Training Command (AETC) requires that individuals selected for SRT pass an APFT within 90 days prior to attending the course. (Tab O-3)

c. Planning and Procedures for the APFT

P1 asked a member from his unit who had administered the APFT before, hereinafter referred to as the fitness monitor (FM), to administer a practice test. (Tab R-31, R-33) No other person was asked to assist with this practice APFT. (Tab R-31, R-33) The FM was familiar with the APFT and how the test was administered. He had not previously received any formal training or certification for administering the APFT or official Air Force fitness assessments. (Tab R-31, R-33) This was a practice APFT, so no official certification was required.

The FM arrived at the 824 SFS at approximately 0655L on 21 January 2010. (Tab R-36) He first checked his computer to see if any lightning warnings had been issued for Moody AFB. (Tab R-38) Then, the FM and P1 got ready to begin the push-ups and sit-ups portion of the APFT inside the 824 SFS building. (Tab R-36) Before P1 began his push-ups and sit-ups, FM demonstrated to P1 how to properly accomplish them and provided a safety briefing. (Tab R-34) The test started inside the 824 SFS building doing push-ups and sit-ups. (Tab R-34, R-36) After they finished the push-ups and sit-ups, they drove over to the start line for the running portion of the test. (Tab R-34, R-36) While P1 was stretching and warming up, a friend of his, Participant

2 (P2), saw P1 and stopped to greet him (Tab R-25, R-36) P1 asked P2 if he would run with him to pace him. (Tab R-25, R-36) P2 agreed and parked his vehicle near the start line. (Tab R-25, R-36)

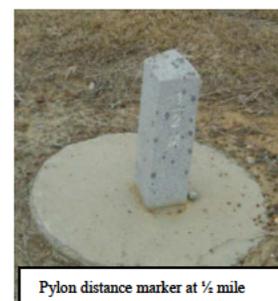
4. SEQUENCE OF EVENTS

P1 was notified on 20 January 2010 that he had been selected to attend the SRT course. (Tab R-11) He was aware that he would be required to pass an APFT before traveling to the course. (Tab O-3, R-11) He made arrangements with the FM to administer a practice APFT the following morning. (Tab R-31)

On the evening of 20 January 2010, P1 woke up his roommate at 2230L, and they each had one alcoholic drink. (Tab R-43) His roommate went to bed after that, and he was not sure what time P1 went to bed. (Tab R-43) The mishap occurred the following morning. The times listed below are approximate local times at Moody AFB on the morning of 21 January 2010.

P1 arrived at work at 0630. At 0700 P1 and the FM proceeded to an indoor area at the 824 SFS building to do push-ups and sit-ups. (Tab R-36) At 0705, P1 started a timed two-minute push-up assessment. (Tab R-36) While the FM observed, P1 completed 55 push-ups. (Tab R-34) He was then given a short break. (Tab R-34) A timed two-minute sit-up assessment started at 0710. (Tab R-36) While the FM observed, P1 completed 54 sit ups. (Tab R-34) They then got in P1's vehicle and drove to the start line for the two-mile running portion of the assessment. (Tab R-34) As P1 was warming up and stretching, a friend, P2, was driving by and saw P1. (Tab R-25, R-36) He stopped to greet P1. (Tab R-25) P1 asked P2 to do the run with him and to pace P1 to help him finish within 16 minutes. (Tab R-25, R-36) The APFT standards listed in Field Manual 21-20 allow for pacing. (Tab AA-31)

The trail used for the run is approximately 4-foot-wide, paved with asphalt; and there is a pylon distance marker every $\frac{1}{4}$ mile. It is relatively flat, which satisfies Field Manual 21-20 requirements. (Tab AA-30) The plan was for P1 to run 1 mile from the start line, then turn around and return to the starting point. (Tab R-36)



P1 began his run at 0733. (Tab R-25, R-36) The FM drove to the one-mile turnaround point to meet P1 and update him on time elapsed. (Tab R-36) By the time P1 and P2 reached the one-mile marker, nine minutes had elapsed. (Tab R-36) At this point, the FM observed P1 looked normal, "like a man who had run a mile." (Tab R-37)

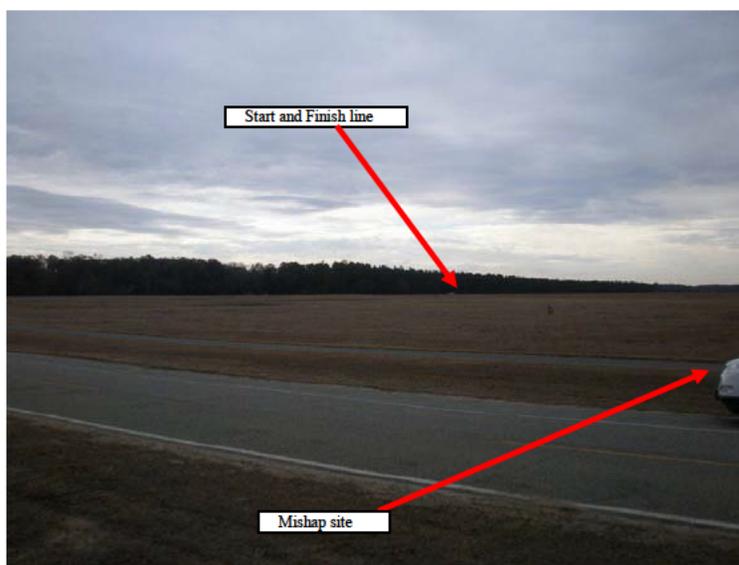
At the 1.5 mile point, between 0746 and 0747, P2 realized P1 would not be able to finish the run within 16 minutes. (Tab R-25) He picked up his pace and ran ahead of P1. (Tab R-25) P1 collapsed at approximately the 1.6 mile point between 0748 and 0750. (Tabs B-3, R-25, R-36) Neither the FM nor P2 observed P1 collapse. (Tab R-36)

At 0750 a bystander, hereinafter referred to as Bystander 1 (B1), who was driving by the track on his way to work at the air traffic control (ATC) tower, saw P1 prone on the ground with his head turned to the left side facing the road. (Tabs R-29, V-1.1)

B1 stopped to check if P1 was okay and queried him as to his condition. B1 observed P1 move his left leg and arm but the movement did not seem purposeful. P1 did not provide a verbal response to the question, but instead was making a moaning noise. B1 parked his vehicle and started moving toward P1, a distance of less than 10 feet. (Tabs R-29, V-1.1)

P1 raised his head and appeared to look at B1, then his head fell back on the ground. At 0751, B1 used his cell phone to call the ATC tower to notify them of the situation and to request medical assistance. (Tabs N-3, R-29, V-1.1)

At 0750 P2 finished the run. The FM was waiting for P1 and P2 at the start line. The FM and P2 looked a little ways up the running trail and saw B1's vehicle pulled over on the side of the road. They did not see P1 anywhere, so they drove to the spot where B1 was parked, which was approximately .4 miles away and approximately a one minute drive. (Tab R-25, R-36)



The FM and P2 arrived to see P1 lying on the ground, and they exited their vehicle and walked

toward P1. They saw P1 lying face down and unresponsive. (Tab R-36, R-37)

Within moments after the FM and P2 arrived on the scene, another member from P1's unit, hereinafter referred to as Bystander 2 (B2), was driving by and saw three people standing by the running trail. He slowed down and noticed P1 lying on the track. He pulled over and got out of his vehicle to help. (Tab R-4)

The FM and B2 looked for signs of P1 breathing. They checked the carotid artery for a pulse, but couldn't find one. The FM turned P1 over on his back and tilted his head back to open his airway. They checked again for breathing or a pulse, but there was nothing. The FM and B2 immediately began CPR with the FM giving rescue breaths and B2 doing chest compressions. (Tab R-4, R-36)

At 0751:54 the ATC tower contacted the 23 MDG and the base Fire Department and informed them there was a man "in need of some medical attention." The Fire Department then asked

what was wrong with P1. At 0753:13 the ATC tower informed the Fire Department that P1 was not “doing so well.” (Tab N-4)

At 0752, P2 called the 820th Combat Operations Squadron (COS) to request one of their medical personnel respond to the mishap site because it seemed like it was taking “too long” for the ambulance to respond. (Tab R-25) The 820 COS has dedicated medical staff, and their building is approximately one mile from the mishap site.

Emergency Medical Services (EMS) dispatched from the 23 MDG at 0753. (Tab DD-4) A driver, an emergency medical technician (EMT) and a paramedic proceeded by ambulance to the mishap site. (Tab V-2.1)

At 0754:22 the ATC tower made a general announcement on the crash net of a medical emergency. (Tab N-6) At 0755 a Physician Assistant (PA) from the 820 COS arrived at the mishap site. (Tab R-18) The PA confirmed P1 was not breathing with no palpable pulse and assisted with CPR by taking over chest compressions. (Tabs R-18, V-4.2) The FM continued with rescue breathing for P1. (Tab R-37)

At 0800 the ambulance arrived on scene. (Tab DD-4) The EMS personnel rapidly assessed the situation and attached a Zoll E Series cardiac monitor to P1. (Tab V-2.1) CPR was continued, and an initial cardiac tracing showed asystole. (Tabs R-18, V-2.1) The paramedic then initiated procedures for a person in asystole. (Tab V-2.1) While CPR was being continued, the EMT attempted to establish an intravenous (IV) line peripherally, but his attempt was unsuccessful. (Tab R-21) They placed P1 on a gurney and onto the ambulance while they continued CPR. (Tab R-18, R-21)

P1 was placed into the ambulance at 0807, and the ambulance departed to go to the ED at the SGMC. (Tab DD-4) SGMC is approximately 10 miles from Moody AFB. During the transit to SGMC, the paramedic intubated P1 with an endotracheal tube (ETT). (Tab R-18, R-21) He then established an IV access in P1’s external jugular vein and gave P1 intravenous doses of epinephrine and atropine. (Tab R-21, R-23) CPR was continued en route. (Tab R-18) At one point, EMS personnel believed they may have momentarily observed P1’s heart change to ventricular fibrillation, so they attempted defibrillation; but this had no effect. (Tab R-21)

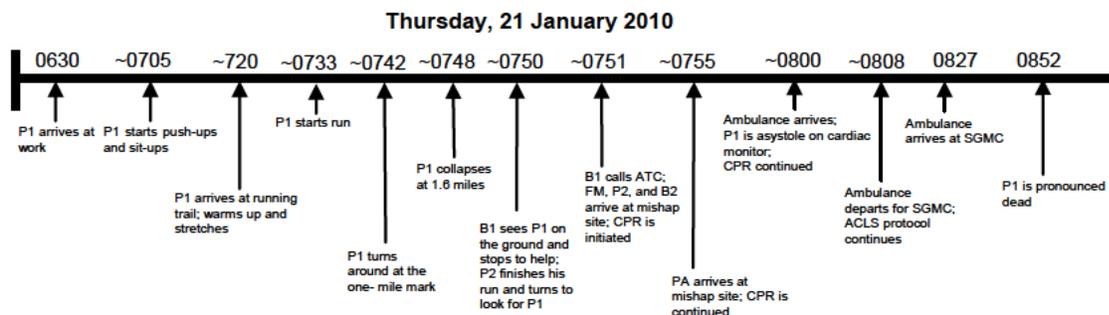


Zoll E Series cardiac monitor

The ambulance arrived at SGMC at 0827. A resuscitative team reevaluated P1. They found no spontaneous breathing and no palpable pulse with asystole on cardiac tracing. They confirmed placement of the ETT and IV access. CPR was continued. P1 was given 3 ampules of sodium bicarbonate to correct acidosis caused by frequent epinephrine injections. P1 continued to be unresponsive to any medical interventions. He was subsequently given

vasopressin, Magnesium, Calcium, and sodium bicarbonate, but he never generated a sustainable heartbeat throughout the entire resuscitation effort. The resuscitation team attempted defibrillation for possible fine ventricular fibrillation, but after defibrillation he maintained a flat cardiac tracing line. P1 remained flaccid with no cardiac tone or pulses with brief interruptions for reassessment in CPR. He was pronounced dead by the attending Emergency physician at 0852. The primary diagnosis in the ED was cardiac arrest. (Tab DD-4, FF-4 thru FF-6)

Timeline of Events



5. MAINTENANCE

Not applicable.

6. EQUIPMENT, VEHICLES, FACILITIES, AND SYSTEMS

All 23 MDG ambulances and equipment are checked for operability daily. The equipment used in response to P1's emergency was a Zoll E Series defibrillator, an ET tube with Ambu bag valve mask and oxygen tanks. The equipment functioned normally. (Tab V-2.1)

There is no evidence to suggest equipment, vehicles or facilities contributed to the mishap.

7. ENVIRONMENTAL CONDITIONS

A weather warning for lightning occurring within five nautical miles was issued for Moody AFB on 21 January 2010 at 0324L. (Tab F-4) The warning was cancelled at 0703L. (Tab F-4) A weather warning for lightning occurring within five nautical miles was issued at 0813L. (Tab F-4) At 0755L there was cloud overcast and it was approximately 57 degrees Fahrenheit. (Tab F-3) It was not raining when P1 started the running portion of the APFT, but it started sprinkling during his run. (Tab R-38) It continued to rain when emergency medical personnel arrived at the accident site. (Tab R-21, R-23) There is no evidence to suggest environmental conditions contributed to the mishap.

8. PERSONNEL QUALIFICATIONS

The emergency responders to the mishap were: (1) initial responders: B1, the FM, B2, and the PA; and (2) EMS responders: the EMT and the paramedic. Emergency response qualifications of these individuals are as follows:

a. Bystander 1

Self Aid and Buddy Care (SABC), attended 15 June 2009 and expires June 2011. (Tab EE-2)

b. The Fitness Monitor

SABC, attended 20 November 2008 and expires November 2010. American Heart Association (AHA) Heartsaver AED Course, attended 19 November 2009 and expires November 2011. (Tab EE-3, EE-4)

c. Bystander 2

SABC, attended 13 August 2009 and expires August 2011. AHA Heartsaver AED Course, attended 18 November 2008 and expires November 2010. (Tab EE-6, EE-7)

d. The Physician Assistant

Certified by the National Commission on Certification of Physician Assistants, expires 31 December 2010. Basic Life Support (BLS) for Healthcare Providers, attended September 2008 and expires September 2010 (this training includes AED and CPR training). ACLS, attended October 2009 and expires October 2011. (Tab EE-8 thru E-13)

e. The Emergency Medical Technician

Certified as an EMT-basic as of 31 March 2009, and his certification expires on 31 March 2011. BLS for Healthcare Providers - October 2008 (expires October 2010). (Tab EE-14)

f. The Paramedic

Licensed in the state of GA(expires 30 September 2010). Advanced Medical Life Support for Providers Course - 17 April 2008 (expires April 2012). ACLS Course – 20 January 2009 (expires January 2011). BLS for Healthcare Providers - January 2008 (expires January 2010-recertified January 2010 expires January 2012). This training includes AED and CPR training. Critical Care Emergency Medical Transport Program (expires 30 March 2010). (Tab EE-15 thru E-19)

The qualifications of all emergency responders met or exceeded standards.

9. MEDICAL FACTORS

The Atlanta Military Entrance Processing Station (MEPS) did a physical exam on P1 on 22 November 2006. This physical exam does not require an electrocardiogram (EKG), and the Atlanta MEPS did not do one. P1 reported no existing or service disqualifying medical problems. The Atlanta MEPS did not conduct any specialized testing or review his preceding medical records. Based on the results of the physical exam at the Atlanta MEPS, P1 was medically cleared for military service.

The autopsy report concluded that P1 died of SCD. This can occur with little to no warning signs or symptoms. SCD refers to cardiac activity suddenly ceasing with immediate cardiovascular collapse and rapid death. For 95% of individuals who die of SCD, autopsy reports reveal cardiac abnormalities. P1's autopsy found him to have a significant hypertrophic cardiomyopathy (enlarged heart) in addition to a hypoplastic (underdeveloped) portion of the right coronary artery. Hypertrophic cardiomyopathy can increase the arrhythmogenicity of the heart tissue. This can result in a nonperfusing cardiac arrhythmia that can rapidly progress to full cardiac arrest. This is the most common cause of SCD in athletic patients younger than 35. Additionally, P1 had a congenitally small right coronary artery (anomalous coronary artery). This is the second most common autopsy finding for young athletes who die from SCD.

There is evidence in the medical record prior to his death, that P1 had asthma. EMS personnel had no problem intubating or oxygenating P1. When a person suffers from asthma their trachea partially collapses or constricts, which makes it difficult to intubate. Asthma also ordinarily causes constriction on the lungs, which makes it difficult to oxygenate. When individuals suffer from asthma attacks they will generally stop to try to catch their breath, then tend to fall backwards. P1 suffered abrasions to his face consistent with him falling forward. The sudden forward collapse of P1 is not consistent with an asthma attack, but is consistent with SCD. The autopsy report listed a finding of pulmonary edema. This is a common finding on patients who die of SCD. There is no evidence that shows asthma was a contributor to P1's death.

P1 had severe allergies to bees, nuts, seafood, and mangos. There is evidence in the medical record prior to his death, that P1 was aware of these allergies. There is no evidence to suggest he consumed any of these foods prior to the mishap. Additionally, no evidence was found to suggest bees were in the area at the time. The autopsy report did not indicate P1's allergies were a contributor to his death.

10. OPERATIONS AND SUPERVISION

P1 was participating in a practice APFT at the time of the mishap. This practice assessment did not require an Air Force certified Physical Training Leader (PTL) or a Fitness Screening Questionnaire (FSQ), although these are required for official Air Force fitness assessments. (Tabs R-31, R-34, AA-4) Prior to the practice APFT, P1 indicated he felt fine and was ready and motivated for the physical training session. (Tab R-35) A FSQ asks the following questions:

1. Do you have a health condition not addressed in a Physical Profile (AF Form 422) that participating in the PT program/testing could aggravate or that would preclude your safety?
2. Do you have any of the following?
 - Chest discomfort with exertion
 - Unusual shortness of breath
 - Dizziness, fainting, blackouts

(Tab AA-5) P1 last completed FSQ in preparation for an official Air Force fitness assessment in October 2009. He answered 'no' to both of the above questions. (Tab G-4, G-5)

There is no evidence to suggest operations or supervision contributed to the mishap.

11. HUMAN FACTORS

A human factor is an environmental factor or individual psychological factor a human being experiences that contributes to or influences performance during a task.

There is no evidence to suggest human factors contributed to the mishap.

12. GOVERNING DIRECTIVES AND PUBLICATIONS

- a. Air Force Instruction (AFI) 10-248, *Fitness Program*, 22 September 2006, incorporating change 1, 22 August 2007
- b. AFI 48-123, *Medical Examinations and Standards*, 5 June 2006
- c. AFI 51-507, *Ground Accident Investigations*, 15 October 2004
- d. Army Regulation 350-1, *Army Training and Leader Development*, 18 December 2009
- e. Field Manual 21-20, *Physical Fitness Training*, 30 September 1992

There are no known or suspected deviations from directives or publications by personnel involved in the mishap or emergency response.

13. NEWS MEDIA INVOLVEMENT

The 23 WG Public Affairs issued an initial press release on 21 January 2010 announcing the death of an airman from the 820 SFG and withholding the name pending notification of the next of kin. (Tab BB-4) A second press release was issued on 22 January 2010 that included P1's name. (Tab BB-3)

Two local newspapers and three local news channels reported the mishap. (Tab BB-5 thru BB-10) There has been no national media coverage of the mishap.

14. ADDITIONAL AREAS OF CONCERN

Not applicable.

28 Apr 10

THOMAS M. WEBSTER, Colonel, USAF
President, Ground Accident Investigation Board