

THE COMBAT EDGE



February 1999

The Combat Edge

Air Combat Command's
Mishap Prevention
Magazine

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
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ACCent on Safety

Last month, I talked to y'all about the Chief of Staff's "January Challenge." As you recall, the Chief had noticed that over the 1990's, USAF-wide, we had experienced more Class A Flight mishaps in January than any other month. As a result, it was appropriate to put some special emphasis on turning that around and shooting for a goal of zero Class A's. Printing cycles being what they are, I can't tell you yet how we did (it's still December as I write this column). But if you'll come back next month, I'll give you a full rundown. (This is obviously a not-so-cleverly-designed plug for your monthly dose of safety awareness training.)

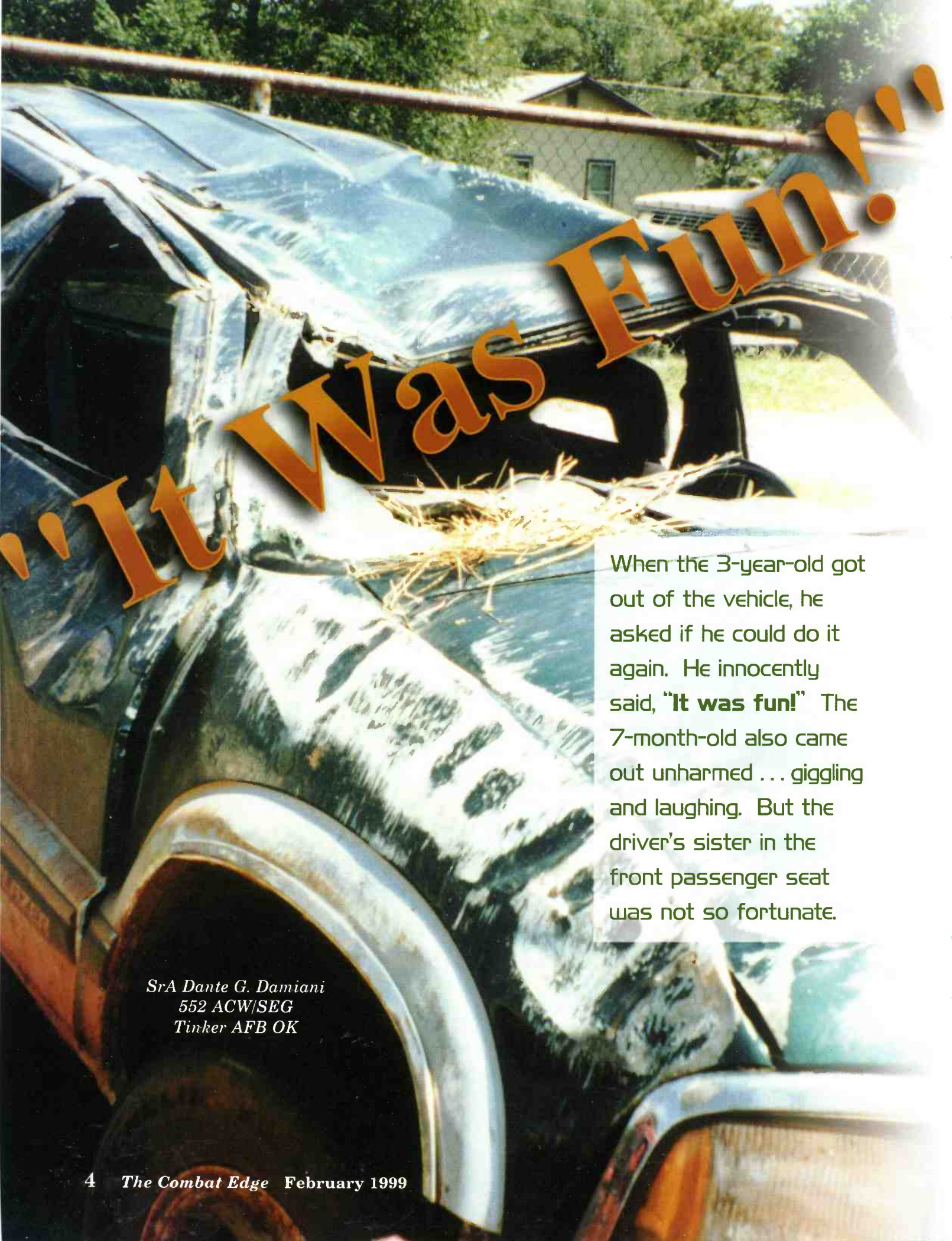
Well, the Chief was right on target with his "January Challenge" for the whole of the Air Force and for the whole of the 1990's, but let's talk about Air Combat Command and our gained units of the Air National Guard and Air Force Reserve Command. ACC stood up on 1 June 1992, so our first January was in Fiscal Year 1993. For the six Januarys that passed 1993 - 1998 (inclusive), we had 6 ACC and Gained Class A Flight Mishaps. On the other hand, during that same period, the six Februarys accounted for twice that number. Yeah, that's right — 12 Class A Flight Mishaps (an even dozen crumpled jets; an average of two each February). Anyway you say it, it still sounds like a miserable record... and it is.

So, what are WE going to do about it?

Well, as for myself, I'm going to take this little bit of info and stick it in the back of my mind. When I start weighing risks and benefits, I'll call it back up and include it in my figuring. I'll think again about those things that were emphasized in "The January Challenge"... things like loss of proficiency and limited recent experience, the effects of weather on man and machines, and the mind numbing effects of "The Dark Ages." And, I'll remember that it's not yet springtime, that I haven't shaken the winter doldrums, and that no matter how I might feel, I'm just not fully back to speed yet. My hope is that I'll cut myself a little slack and not overtask myself; I'll leave a little more "pad" for error, and I'll even double-check to make sure I get those tech order steps right. Those are the things that will help me through February without taking needless risks. It would be even better if you'd do 'em, too; together we can cut the risk to both of us and have greater odds at still being around in March!

Come on — stick with "The Challenge!" Let's make a difference in 1999.

Colonel Turk Marshall
Chief of Safety



It Was Fun!!!

When the 3-year-old got out of the vehicle, he asked if he could do it again. He innocently said, "**It was fun!**" The 7-month-old also came out unharmed . . . giggling and laughing. But the driver's sister in the front passenger seat was not so fortunate.

*SrA Dante G. Damiani
552 ACW/SEG
Tinker AFB OK*

Imagine you're planning a vacation to visit relatives this fall. If driving, you will likely think about gas, money, food, and where you are going to stop for breaks. But how many of you are thinking about what you can do to prevent injury in case you lose control of your car? Not many, I'm sure. Now you're probably thinking, "Oh no, not another seat belt story!" Well, I'm here to tell you, "Oh yes, it surrrrrre ... is!" But it's a good one, and it's true! Here's what happened.

Wearing a seat belt saved the life of an airman in our wing, and it saved the lives of three of her family members as well. It all started when she decided to go with her family to visit relatives for a week. They made sure they had plenty of sleep the night prior to their departure and were well prepared. In fact, before leaving town, they even stopped at a garage and purchased a spare tire ... just in case of an emergency. The driver and her sister were securely strapped into the front seat belts of their four-door Chevy Blazer, and the driver's two young children were safely snuggled in their car seats. Needless to say, the family was "ready to go!"

While traveling west on Interstate 40, en route to New Mexico, tragedy struck. It was approximately 9:30 p.m. As the airman was driving, she turned around in her seat to look at her children. In the process of doing so, she caused the vehicle to swerve right. In an attempt to regain control of the vehicle, she jerked the steering wheel back to the left ... not realizing that the cruise control was still set at the speed limit.

The sudden movement of the steering wheel combined with the rate of speed prevented her from regaining control. The vehicle struck

the curb, went airborne, came down on its side, slid along the side of the road, and eventually rolled down an embankment. The vehicle flipped over seven times and then stopped upside down.

The driver crawled out unassisted. Some helpful motorists then pulled over to assist in removing the rest of the passengers from the wreckage. When the 3-year-old got out of the vehicle, he asked if he could do it again. He innocently said, "**It was fun!**" The 7-month-old also came out unharmed ... giggling and laughing. But the driver's sister in the front passenger seat was not so fortunate. Paramedics had to remove her from the wreckage, and she sustained serious injuries as a result of the multiple impacts the vehicle received to its right side. She suffered a broken leg, broken wrist, dislocated shoulder, as well as numerous lacerations and contusions. The driver received a puncture wound to her left hand from pieces of glass and a bruised left lung. All rescue agencies at the scene of the accident agreed that without the use of appropriate restraints, one or more of the occupants would have certainly received "fatal injuries."

According to the National Safety Council publication, "Accident Facts: 1996 Edition," from 1982 to 1994, an estimated 65,290 lives were saved by seat belts and more than 1.5 million moderate-to-critical injuries were also prevented. An additional 9,529 lives could have been saved in 1994 if all passenger vehicle occupants over age 4 wore safety belts. In addition, an estimated 2,655 lives have been saved by child restraints from 1992 to 1994. These numbers are not trivial; they are very important! They reveal that seat belts and child safety seats are proven life savers.

[Note: Never put a rear-facing child seat (i.e., those used with infants) in the front seat of a car with an air bag. In fact, make sure all children are buckled up no matter where they sit. Also, don't forget that the rear seat is the safest place for children of any age to ride.]

Here's the moral to this story: Remember to always buckle up with a lap and shoulder belt, and always buckle your children in child safety seats. Seat belts do save lives; just ask the driver in this story — she's a believer in seat belts. If you had experienced what she went through, you'd be the same way. Make a decision now to set a pattern for life in the proper use of seat belts. For safety's sake, "Buckle Up!"

While this article once again proves the value of using seat belts, the story also points out another critical factor in driving safety. This concern is the need to remain focused on the task of maintaining constant control of your vehicle... especially while driving at highway speeds. When driving your automobile, you should never allow yourself to become distracted — not even temporarily. To do so increases the risk of losing control of your vehicle. In this particular case (and I realize that hindsight is always 20-20 vision), the driver should have enlisted the help of her adult passenger in checking on the children in the back seat of the vehicle in lieu of turning around and taking her eyes off the road. Remember... driving is a "full-time job," and we cannot allow distractions — of any sort — to put us into high risk situations. ■

- Ed.

Ask Orville!

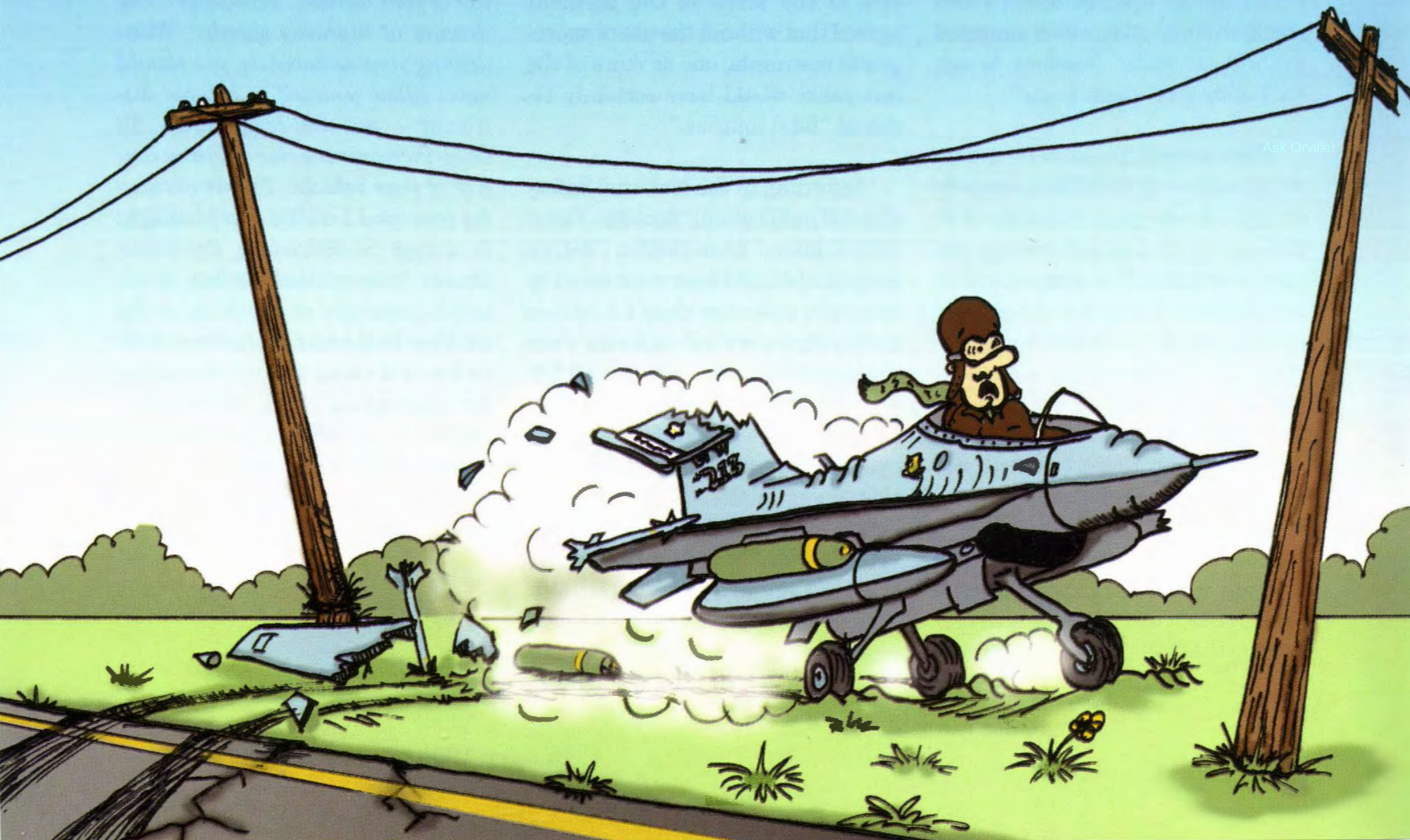
Col Ronald L. Garhart
HQ ACC/SEO
Langley AFB VA

Frangibility? What's that? Simply said, it's a big word for "easily broken or breakable." And believe it or not, it's an important air base siting criteria. Hmmm... frangibility... easily broken... breakable... airfield planning. What's the connection? How can frangibility be an Air Force requirement? Well, here's a brief explanation. Due to their fixed function, airfield facilities (such as lights, signs, navigation facilities, and weather equipment) are oftentimes installed in areas which are otherwise required to be free of obstacles. By regulation, these installations — to the extent practical — are required to be built of "frangible or low impact resistance construction." The advantage of this "frangible" design is that if it is hit by an aircraft during takeoff or landing, the frangible structure breaks away in such a manner so as to do minimal damage to the jet and its crew member(s). Frangible airfield facilities are easily broken/breakable; as a result, this type of construction minimizes hazards to aircrew as well as damage to aircraft in the event of a mishap. Orville is a strong believer in frangibility; to find out why, read on.

- Ed.

Dear Orville:

Please do not use my name or organization in your column. I want you to know that I am becoming increasingly disillusioned with ORM, and here is why. Our base recently lost an aircraft when the jet departed the runway and was destroyed after impacting numerous obstacles in the Clear Zone. In addition, the pilot was forced to eject and died as a result. The ensuing investigation showed that the localizer array, antenna pad, a field monitor, and the power signal pedestal did not meet the "frangibility" requirements of Air Force Joint Manual (AFJM) 32-1013, Volume 2, "Planning Criteria and Waivers for Airfield Support Facilities," Para 3.3. So we promptly accomplished an ORM application. The results of our risk analysis? In order to mitigate



the hazard resulting from non-frangible construction, we applied for a waiver to the frangibility requirements. But even though we did everything right and used the ORM process to arrive at our recommendations and request for waiver, it looks as if the waiver will be denied. I'm at a loss here, Orville... what gives?

*Sincerely,
"Confused About ORM"*

Dear Confused:

Allow me to summarize the issue at hand, as I understand it. In clear violation of prevailing guidance, non-frangible obstacles in the Clear Zone were constructed without obtaining a waiver. Then as a result of a mishap in which an aircraft was destroyed and a pilot killed when it impacted those unyielding obstacles, "ORM" was used to identify the hazard as "not having a waiver," and to identify the appropriate control measure as "obtaining a waiver."

Let's try to evaluate the predicament from both viewpoints. If the goal of the ORM endeavor was to preclude any and all condemnation that might surface as a result of a future mishap in the said Clear Zone, then I think your organization did just fine. But on the other hand, if the people reviewing your request had actually expected you to risk manage the situation so as to avoid another loss of aircraft or life, I can sort of see why they were less than inspired

by your attempt at ORM. So where do we go from here?

Fortunately we have a group of dedicated Air Force professionals who conducted the ORM process on your precise predicament a long time ago, and here is what they came up with.

Step 1 - Identify the Hazard: They identified immovable objects in the path of an aircraft that is experiencing an emergency situation as a potential hazard during runway operations.

Step 2 - Assess the Risk: They identified an area (which we now refer to as the Clear Zone) as the most likely place for the hazard to be encountered. They assessed the severity of an emergency aircraft striking the hazard as catastrophic (loss of life or aircraft). Placing the information on the old risk assessment matrix, they came up with a "high" to "extremely high" risk rating. In other words, something needs to be done to reduce the risk; and the fix requires MAJCOM or higher approval.

Step 3 - Analyze Control Measures: One of the most promising control measures analyzed was the use of frangible construction on obstacles that absolutely had to be located in the Clear Zone. By using the frangible design, any damage to the aircraft and potential loss of life would be greatly reduced. Even some highway departments are now using this approach for formidable obstacles immediately to the left and

right of the road surface (the road warrior's clear zone).

Step 4 - Make Control Decision: This group of experts must have had their act together because they sold the concept of using frangible design.

Step 5 - Implement Risk Controls: They were also a wise and savvy group. They had the foresight to make compliance of this new control measure mandatory by putting the requirement in AFJM 32-1013, V2, Para 3.3.

Step 6 - Supervise and Review: But low and behold, our fine flock of professionals could not foresee that people and organizations would blatantly disregard the mandatory compliance requirements in order to save a buck or whatever other excuse seemed appropriate. So our well-meaning ORMers still have some work to do. They must find a way to convince you that the use of frangible design in the Clear Zone is in your best interest, and they must find a way to put some teeth into the requirement.

Still confused? Then here's an observation and a few predictions. We lost two aircraft and a pilot in recent mishaps in which Clear Zone construction did not meet compliance requirements. As a result, I would expect to see: (1) a strong emphasis to make all new construction in the Clear Zone of frangible design, (2) waivers turned down at a record setting rate, and (3) a sense of urgency to replace all existing non-frangible objects in Clear Zones. Remember, you heard it here first!

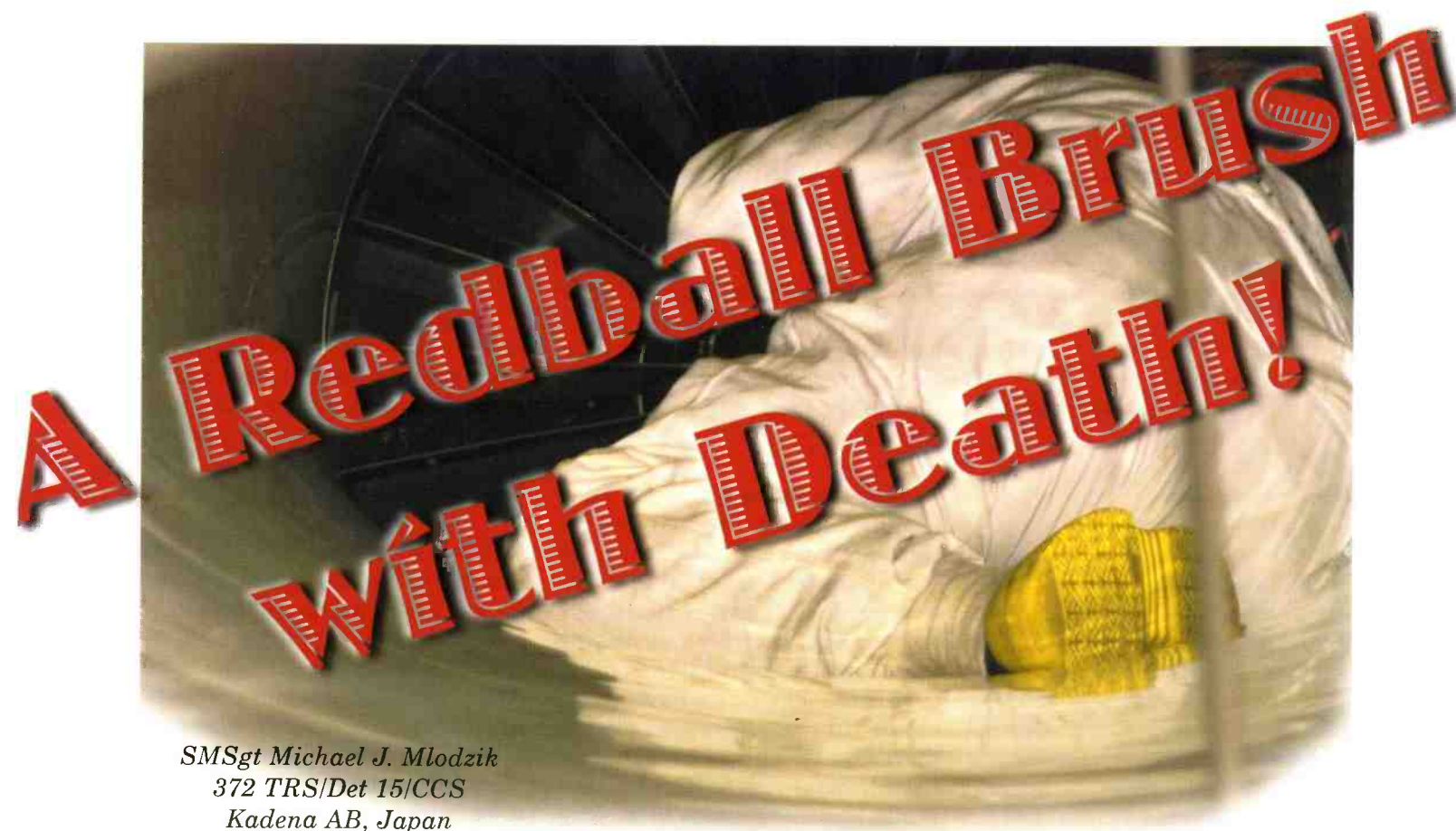
Keep those cards and letters flying in,

Orville R. Mudd
ORM Dogfight Veteran
ACC Office of Safety

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*SMSgt Michael J. Mlodzik
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Have you ever been rushed to get that sortie? Have you ever pushed the limits of time to meet that take-off? Well, let me tell you about an event where both of the above mentioned questions almost killed a friend of mine. It was a normal flying day; launch the jet, scramble the people to the hot-pits, manage the lunch schedule, and recover the aircraft.

The sun was shining along with a refreshing breeze — it was beautiful outside. We were flying pit-n-goes. It was to be no different that day, except we had to divert an F-16 aircraft back to chocks when it squawked Code-3 after hot-pits. We were fortunate that this aircraft was first on the hot-pits. With the production super's quick thinking, everyone's objective was to fix the aircraft while the other jets were refueling. If we could repair it in time, the jet would then be able to meet up with its four-ship at the end-of-

runway. We envisioned success. We hoped we could fix the aircraft and avoid the stigma of a Ground Abort and the additional workload for swing shift. Clearly stated, "We wanted this jet to take off!" We had the knowledge, enthusiasm, and people to prove it!

The crew chief shut down the aircraft, and the specialists approached the aircraft with computers and technical data in hand. People galore were focused on getting the aircraft fixed and turned. We wanted to make sure we did all we could, so there were actually more people than required to turn the jet. It's one of those precautions maintainers take... the more resources, the better the chance we have of turning the jet in a shorter period of time. There were five or six people with speedhandles opening the panels, and at least seven other people were scrambling around performing odds and ends in an organized fashion. It was like

a well oiled machine; it was a routine redball. Everybody knew what their specific task was. We were professionals of the trade and kept the mission in mind — generate the aircraft!

As the specialists were reprogramming one of the aircraft's many computers, the crew chiefs were taking oil samples and roving over the aircraft accomplishing the thru-flight inspection. Then, one of my co-workers went down the engine intake to do an inspection. There was lots of noise from the -60 ground power unit, too many people to keep track of, and everyone was in a hurry. The situation was prime for a catastrophic event. You could almost feel it in the air.

The specialists were done reprogramming the aircraft, and (in order to save time) the plan was for the pilot to perform the operational check "after" engine start. By doing this, we were confident we would make the sortie without a

deviation to the flying schedule. The aircraft panels were going back up, and the production super was waiting for the technicians to complete the forms. The crew chiefs were doing their last foreign object check and cleared the area for engine start. The pilot remained in the cockpit during the redball, and the technicians were scrambling everywhere doing their tool inventories — entering and clearing forms entries. Then the production super gave the “thumbs up” to the pilot indicating the forms were cleared, and the jet was good to go.

The pilot switched on the main power switch and established communication with the crew chief. The crew chief cleared the pilot forward and aft; the pilot commenced to start the aircraft. He switched the JFS switch to Start 1, the doors opened, the JFS began to spin-up, the specialists had their fingers crossed, and the sound of a successful redball was in the air. The technicians were anxiously awaiting idle speed for the operational checks. Then... all of a sudden... we saw legs dangling from the intake lip. Next, a whole body appeared! Scrambling for his tech data, mirror, and flashlight, my co-worker finished his intake lip inspection and quickly cleared the area. The launching crew chief, standing at the left rear of the aircraft, never saw what was going on — neither did the pilot. However, everyone standing around and sitting in their trucks saw the unthinkable — somebody was in the intake safety zone! For those of you that don't know the F-16 aircraft, it's like a giant vacuum with more suction than you would believe. We almost had a mishap due to the enthusiasm and drive we had in proving we could generate that aircraft, not to mention overlooking certain critical supervisory responsibilities on the part of the person in charge of the aircraft.

Immediately a small convention formed at the right rear side of the aircraft, the engine was started and nobody could hear a thing. Arms were in the air with lots of shout-

ing going on. Everybody was kind of in a mode of shock, but we continued with the mission and got the jet rolling. Nobody really realized the impact of what had just transpired because there was still too much confusion. My friend jumped in the production super's truck, and you can imagine the verbal words that were flying around. Needless to say, articulate expressions were bouncing off the windows and dashboard. They stared at each other in disbelief, shook their heads, reaccomplished the forms, inventoried the tools, and the jet rolled on time.

What is the lesson here? We are commonly faced with challenges; and as maintainers, we routinely perform redball maintenance. However, we don't normally push the envelope on killing our friends (i.e., those people that work for us, with us, as well as those that we work for). In this case, the redball forced too many people into a chaotic situation. Even though everyone's hearts were in the right place, the job was rushed, the paperwork wasn't completely finished, and the “thumbs-up” was given too early. If you determine — at any point in time — that continuing an ongoing operation is unsafe, you need to speak up and say, “Stop! This is unsafe!” Each of us are empowered to help prevent a major catastrophe, especially when a person's life is at stake.

How many times have you heard or read the following quote? “Not a single sortie we fly is worth compromising the integrity of an aircraft or the life of an airman.” Folks, no sortie is worth it! We pushed the envelope that day; and it almost cost us the life of a fellow airman. Just for your information, my friend came out of the intake and performed a surrounding area intake inspection before he ran to the back of the aircraft. From his actions, you may ask, “Why didn't he try to stop the operation?” Well, he had the same mentality that everybody else did at the redball — “Let's get the sortie!”

Interestingly enough, one thing that remains a mystery to me is that the pilot (our squadron commander) never knew what was going on until he returned from the sortie. We thought it was best that way, you know... keep his mind on flying and stuff like that. Sure, he saw lots of people scrambling; but he got the “thumbs up” and pressed on as if it was business as usual. But when he returned from the mission, guess who was waiting to brief him on the almost fatal mishap? You guessed it — ME! However, before I got a word in, he mentioned how professional we were during the redball and that he was impressed with our hustle to fix his aircraft. At that time, I didn't have the heart to say anything, but I had to anyway. When I told him about what had transpired, I saw his eyes well up and a lump in his throat form that wouldn't go down easy.

Talk about embarrassing on my part... but that wasn't the half of it! The incident was a devastating blow to our commander's confidence in our safety practices. I often think back to the situation and wonder how we could have prevented it. Have you ever seen the professionalism, pride, and drive of maintainers? We want more than life itself to get a jet airborne.

We find ourselves “jumping through hoops of fire” to make things happen. But one thing I can't emphasize enough is the fact that with all our drive and experience, we need to remember that we can still control the situation by limiting the number of people in an area and — most of all — by understanding what is going on around us. Know who is where, what forms need to be completed, and ensure you are doing the job right by the book and as safely as possible. Sure we had to start back at ground zero to regain our commander's confidence level; but most of all, I'm glad my friend is still with us. So next time the fire gets hot in a redball, try mellowing it out with a cool head. Somebody's life depends on it! ■

Monthly Awards

AIRCREW SAFETY AWARD OF DISTINCTION

*Lt Col Richard G. Horton, Capt Ralph E. Bentley, Maj Andrew L. Parrish
336 FS, 4 FW, Seymour Johnson AFB NC*



Lt Col Horton and Capt Bentley were in the lead of a two-ship element of F-15E Strike Eagles returning to Incirlik AB, Republic of Turkey, from an Operation NORTHERN WATCH (ONW) sortie. Twenty miles prior to the Tactical Area of Operations Checkout point, the crew noticed a master caution light. Investigation revealed a failure of the utility hydraulic "A" system, confirmed by an accompanying drop in operating pressure of the aircraft's utility hydraulics. While Capt Bentley went to the checklist for the proper procedures, Lt Col Horton slowed the aircraft and began coordinating for other coalition aircraft in the vicinity to safely pass them.

The mishap crew was faced with other problems beyond the scope of their aircraft malfunction. Combined Task Force Operational NORTHERN WATCH is made up of ground and air forces from the Republic of Turkey, the United Kingdom, and the United States Air Force and Navy. Over 10 different types of aircraft operate out of Incirlik Air Base in support of ONW, and the varying performance characteristics and limitations of these aircraft had to be taken into account. To further complicate matters, the north parallel taxiway at Incirlik, which doubled as the alternate landing surface, was under reconstruction at the time. The nearest suitable military divert field was the Turkish air base at Konya, over 150 miles to the northwest. All these factors weighed on the minds of the crew as they considered their next step. In addition, Lt Col Horton, as the 6-ship flight lead, coordinated mission audibles with AWACS and the Mission Commander ensuring that the ONW mission objectives were met.

The mishap crew checked out with AWACS and declared an emergency with Incirlik approach. They then contacted the Supervisor of Flying, Maj Parrish, advising him of the malfunction and informing him that they would require an approach-end cable engagement. While the crew continued toward Incirlik and began to run the first of many checklists, Maj Parrish swung into action. In short order, he confirmed the positions and fuel states of all remaining ONW aircraft airborne and coordinated for them to land as soon as possible. This was required because many of the aircraft would be unable to land on the runway once the approach-end cable was rigged. He briefed air traffic controllers and crash recovery crews on the plan and alerted barrier maintenance crews to rig an approach-end cable as soon as all but the mishap aircraft had landed. Maj Parrish correctly assessed that the stricken Strike Eagle's landing speed would be faster than normal because of the extremely hot weather and the aircraft's load of live missiles and laser-guided bombs. With this in

mind, he directed the barrier crews to rig the secondary approach-end cable, which was farther down the runway. With the high incidence of bird activity and two recent bird strikes, Maj Parrish also ensured that all bird reduction methods were being used during the recovery. The mishap crew entered holding 20 miles east of the field and completed their checklists up to alternate landing gear extension. When all coalition aircraft had landed and the cable was rigged, they performed the landing gear alternate extension procedure and flew a flawless straight-in approach to the active runway. The barrier engagement was successful, and the crew remained with the aircraft while it was removed from the cable and towed off the runway.

The aircrew's accurate assessment of the situation, excellent airmanship, and outstanding crew coordination, coupled with the SOF's quick and decisive action, kept a potentially complex situation from exploding into a serious incident.

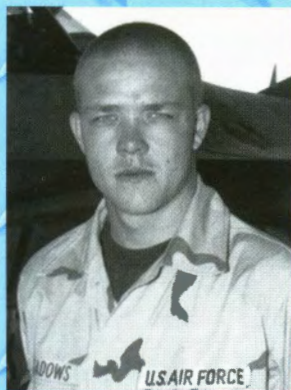
PILOT SAFETY AWARD OF DISTINCTION

Maj Eric S. Overturf, AATC, Tucson AZ

Tigre 83 was on what would normally be considered a low threat cross-country sortie; if there is such a thing in a single-engine fighter! Twenty-five nautical miles west of El Paso International, the tone of the sortie took on a drastic change when his aircraft suffered catastrophic engine failure and flamed out. This all occurred at 18,000 feet above ground level and 550 knots true airspeed. Every F-16 pilot knows that the rule of thumb for simulated flameout (SFO) landings is to be at an altitude (thousands) equal to your distance from the intended landing. If you do the math in this problem, it is obvious that any delays in turning back would have resulted in a completely different outcome. Even with Maj Overturf's immediate execution of the critical action procedures, this SFO would require all of his piloting skills to safely recover his crippled F-16 to a heavily populated area. In fact, had this occurred a mere 30 seconds later, the Air Force inventory would be short one F-16C. It's situations like this that help reinforce the single-engine mentality of always being aware of the closest piece of concrete.

Maj Overturf quickly analyzed the situation and attempted an airstart, which was later determined to be futile. Throughout the airstart attempt, Maj Overturf continued with his flameout landing procedures and communicated his situation to El Paso Tower. Engine indications made it advisable not to start the auxiliary jet fuel starter to help power his flight controls and electrical systems...it was all up to the emergency power unit. Albuquerque Center was quickly informed of the emergency situation and promptly cleared the airspace back to El Paso International. Maj Overturf expertly controlled his energy and delayed lowering his landing gear until he was assured of making it to runway 04 and with only emergency bottles powering his brakes was able to stop the aircraft in less than 8,000 feet (runway length - 11,000 feet).

This story had a happy ending due solely to the cool, calm actions of Maj Overturf. So, the next time you see an F-16 doing what you think is a very high overhead approach, you might take the time to wonder if it's practice or...???



CREW CHIEF SAFETY AWARD OF DISTINCTION

*A1C Eddie Meadows, II, 55 FS, 4404 WG(P)
Prince Sultan AB, Saudi Arabia*

On 28 Sep 98, A1C Meadows prepared to launch an F-16 aircraft in support of Exercise Sand Storm 98-1 in the 120-degree heat of Prince Sultan AB, Saudi Arabia. This exercise was the first United States and Royal Saudi Air Force combined Dissimilar Air Combat Training Exercise in the history of the United States Air Force. During engine start, Amn Meadows positioned himself behind the left slab of the F-16CJ to monitor the Jet Fuel Starter (JFS). As the JFS spooled up, Amn Meadows noticed a small, almost imperceptible piece of metal sticking out of the drain hole in the bottom of the F-16. He quickly informed the pilot of the discrepancy and proceeded to prepare the spare aircraft for launch ensuring the scheduled sortie launched on time. Maintenance later discovered that the small piece of metal was actually a screw belonging to the JFS/Brake accumulator door. Had Amn Meadows not noticed the screw in the drain, there would have been a high potential for an engine fire or catastrophic engine failure during the flight. Amn Meadows' professionalism and attention to detail not only ensured the success of Exercise Sand Storm 98-1, but prevented the possible loss of life as well as a 28 million dollar 4404th combat asset.

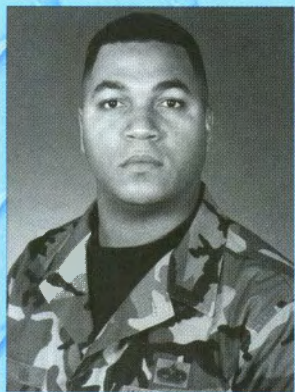


FLIGHT LINE SAFETY AWARD OF DISTINCTION

SSgt William R. Payne, Jr., 56 RQS, 85 GP, NAS Keflavik IC

SSgt Payne was the flight engineer on a briefed two-ship tactical training sortie. During the aircraft run up, as the throttles were advanced from idle to fly, it was noted that the #2 Nf and torque were much higher than #1 indications at identical throttle settings. This was briefly discussed and dismissed as a slight rigging difference. During a subsequent engine health indicator check, Sgt Payne noted that once again the #2 Nf was irregular. The throttle was retarded to idle with Nf reading 95%, while the #1 throttle indicated the typical 89% Nf at idle. Although the crew was content to once again dismiss this as a slight rigging problem, Sgt Payne insisted on further investigation. At this point, maintenance was called in to investigate. The engine expert stated that none of the noted engine indications were addressed by his technical guidance and any further investigation by maintenance would necessitate shutting the aircraft down. The aircraft commander, based on this information from maintenance, was willing to take the aircraft and suggested this to the crew. Sgt Payne, however, did not feel that the aircraft was airworthy. He voiced his opinion and recommended the aircraft be shut down and turned over to maintenance for additional troubleshooting. The decision was made to shut down the aircraft. During shutdown, the crew noted a 5% split between the gas generator speeds of the engines, exceeding the 3% allowable split between the two engines. Maintenance investigation into the problem following the shutdown revealed a sheared load demand spindle pin.

Sgt Payne's persistence, despite the fact that it was in opposition to his aircraft commander's suggestion, is particularly noteworthy in this instance. His excellent employment of Crew Resource Management certainly averted an in-flight emergency and possible damage to the aircraft and crew. Not only does Sgt Payne's "Good Catch" indicate a superior degree of aircraft systems knowledge, but his decision to make the unpopular call to terminate the mission illustrates his commitment to Operational Risk Management. No degree of unnecessary risk is acceptable on a training mission. Thankfully, Sgt Payne was on board to remind everyone of this fact.



WEAPONS SAFETY AWARD OF DISTINCTION

TSgt Patrick Lide, 1 EMS, 1 FW, Langley AFB VA

TSgt Lide was the crew chief during a munitions Storage Monitoring Inspection (SMI) involving white phosphorus (WP) assets. During the inspection, Sgt Lide identified a slightly frozen layer of ice forming on top of water barrels used for immersing WP items in case of leaks. Sgt Lide was concerned that the water within the barrels could freeze thereby making them unusable for fire protection measures. Realizing this potentially hazardous situation, Sgt Lide prepared an AF Form 1000 suggesting the addition of propylene glycol (antifreeze) to the water source to prevent freezing. Initial wing level review revealed that the introduction of WP munitions into antifreeze solutions raised concerns about the possibility of spontaneous combustion. His suggestion was forwarded through Fire Department and HHQ safety channels for testing to determine effects on WP and antifreeze mixtures. Sgt Lide's concern for the safety of his co-workers motivated him to spearhead a campaign to gather explosive data. He personally contacted the WP item manager and the antifreeze developers to determine if the hazard potential would be increased by exposing WP to the antifreeze and water solution. He also contacted HQ USAF Environment. Explosive data for WP and antifreeze mixtures was later reviewed and approved for use by the Air Force Safety Center. The Environmental Technologies Branch determined that the environmental impact of antifreeze exposure would present a minimal-to-nonexistent risk factor. This process has been approved for field use and will be included in the re-write of AFMAN 91-201, Explosive Safety Standards. Sgt Lide's innovative performance and attention to detail directly reduced the possible loss of life while enhancing munitions maintenance safety practices throughout Air Combat Command and the Air Force.



GROUND SAFETY AWARD OF DISTINCTION

SSgt Michael E. Lukawski, SSgt John E. Edgington (photo unavailable)
552 ACW
Tinker AFB OK

Earlier this year, Staff Sergeants Lukawski and Edgington were dispatched to an E-3 Sentry Airborne Warning and Control System (AWACS) aircraft to troubleshoot an equipment cooling malfunction. While working in the radio access compartment just below the cockpit, they noticed burn marks around an electromagnetic pulse suppression box. Concerned that an immediate fire hazard may be present, they quickly had all personnel cease work on the aircraft, removed external power, and notified the production superintendent. The Logistics Group Commander was also notified and the aircraft was subsequently impounded. Sergeants Lukawski and Edgington were tasked to inspect the compartment to determine the cause of the damage. They found the number eight transformer-rectifier unit showed signs of severe overheating as well. Upon further inspection, they determined the transformer-rectifier unit had failed internally as evidenced by several burnt capacitors. Had the failure not been identified prior to the next flight, an aircraft fire and catastrophic loss of electrical power could have resulted, both serious in-flight emergencies. Sergeants Lukawski and Edgington's attention to detail and decisive actions in this situation prevented further damage to a vital national asset and removed a serious risk to our aircrew's safety.



UNIT SAFETY AWARD OF DISTINCTION

71st Fighter Squadron, 1 FW, Langley AFB VA

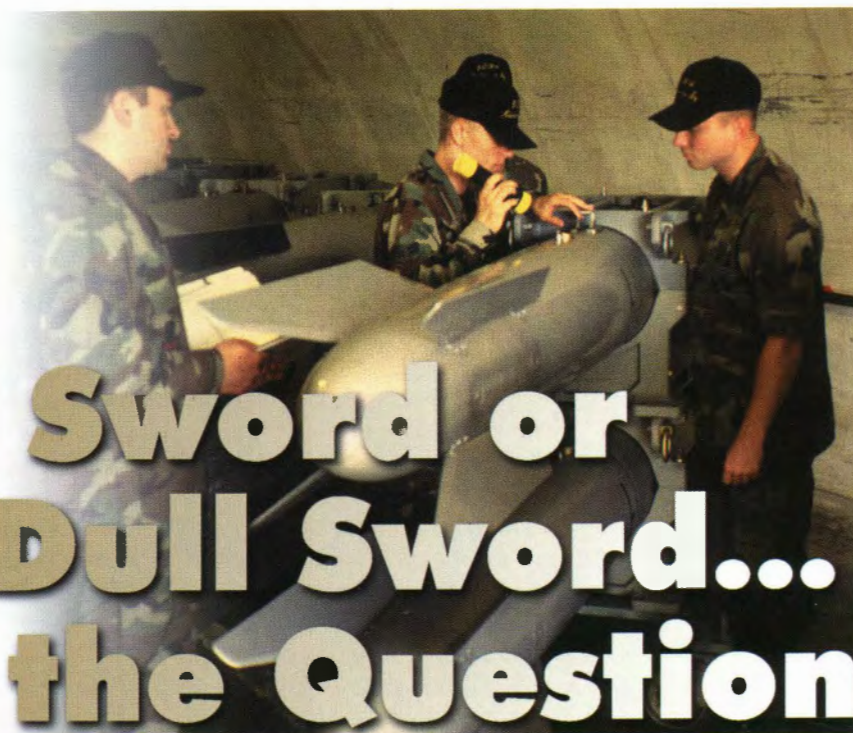
The 71st Fighter Squadron personnel improved the safety of aircrew and maintenance technicians and increased weapon system effectiveness during their deployment to Saudi Arabia in support of Operations SOUTHERN WATCH and DESERT THUNDER. Prior to the squadron's deployment to the AOR, nose tires on two F-15C aircraft at Prince Sultan Air Base catastrophically failed on landing, destroying one F100-PW-100 jet engine and causing more than one million dollars worth of damage.

Squadron supervision briefed these failures to aircrew and maintenance personnel, stressing the importance of slower taxi speeds to the former, and thorough tire inspections to the latter. The squadron's response was impressive! During the 60-day deployment, pilots slowed taxi speeds, reducing stress to the nose tires to a minimum. The maintainers meticulously examined nose tires when the aircraft returned to the chocks following flight and discovered 10 blisters. In addition, the End of Runway inspection crew found three nose tires with blisters prior to takeoff, preventing catastrophic failure of the tires and damage to aircraft and crew.

The squadron did not stop with the tire inspections. Instead, they submitted all 13 nose tires as Product Quality Deficiency Reports and began to track the number of sorties on each tire for all squadron aircraft. Using this data, maintenance supervision discovered that the nose tires were failing after an average 25 sorties. Without direction from depot engineers or higher command, the squadron adopted a time change criteria for nose tires, requiring tire changes every 20 sorties. It was a full 2 weeks after the squadron adopted this policy when Air Combat Command directed nose tires to become a time change item.

The proactive stance members of the 71st Fighter Squadron took upon their arrival in Saudi Arabia improved the safety of both aircrew and maintenance personnel. In addition, it improved the effectiveness of Wing F-15C aircraft that were vital to the accomplishment of Operation DESERT THUNDER and the continued accomplishment of Operation SOUTHERN WATCH.

*MSgt Thomas S. Foster, Jr.
HQ ACC/SEW
Langley AFB VA*



To Dull Sword or Not to Dull Sword... That is the Question

Do you ever wonder if anyone is looking at those Dull Sword Reports you submitted or if they even care about your problems? Well, we do! In addition to us at the ACC Office of Safety, the Air Force Safety Center (AFSC) has also taken an active role in the Dull Sword program. The Air Force's goal for Nuclear Mishap and Safety Deficiency reporting is to prevent nuclear weapons system accidents and incidents and to bring actual or potential nuclear safety problems to the attention of agencies responsible for evaluating and correcting them.

In support of this goal, AFSC recently released a message entitled Clarification of Dull Sword Reporting Requirements for Nuclear Weapon-Related Safety Deficiencies (Date Time Group 271806Z Oct 98). In addition, the latest revision to Technical Order (T.O.) 11N-5-1, "Unsatisfactory Reports," dated 1 October 1998, is now available. AFI 91-204, "Safety Investigations and Reports," is still in coordination within HQ AFSC; however, the fol-

lowing information provides clarification of Dull Sword reporting requirements outlined in this AFI.

When the defective design, failure, or minor damage of a nuclear weapon, nuclear weapon component, or Department of Energy (DOE)-designed item is related to a "safety deficiency," a Dull Sword Report is required to be submitted. In addition, preparation of an Unsatisfactory Report (UR) per T.O. 11N-5-1 is required. However, when such a problem does occur — but is "not" safety related — a Dull Sword report is "not" required; only a UR would be required per T.O. 11N-5-1.

This clarification in reporting requirements is consistent with the new T.O. 11N-5-1 and will be clearly defined in the upcoming release of AFI 91-204. Responsibility will lie with the wing safety office to determine if a report needs to be processed as a Dull Sword or UR. In support of this requirement, maintenance personnel are responsible for assisting the wing safety staff during the initial reporting process

by quickly and accurately providing information for the Weapon Safety Manager (WSM) to evaluate. Once the WSM carefully considers all the facts surrounding the incident, the WSM (not element personnel) will decide whether or not to report the deficiency as a Dull Sword or UR.

Everyone involved in reporting nuclear accidents, mishaps, or deficiencies must be aware of all program safety requirements. Without close coordination between the equipment maintainers, weapon system operators, MAJCOM evaluators, and the safety staff, the ability to gain valuable information from one of the Air Force's most important mishap prevention programs will be diminished. In this business, there is no margin for error. A 100% commitment on the part of every individual involved with the safe operations and maintenance of America's nuclear weapons stockpile is absolutely critical. What will it be? Success... or failure? It's up to you! ■

CONFINED SPACES

SMSgt Gary Reniker, USAFR, 442 FW/SE, Whiteman AFB MO

If you work in a confined space as part of your regular duties, you face a high risk of injury or death from associated hazards. The Occupational Safety and Health Administration (OSHA) estimates that about 63 workers die and 5,000 workers are injured from entry into boilers, aircraft fuel cells, pits, reaction or process vessels, septic tanks, silos, fuel tanks or other similar enclosures each year. These alarming statistics demonstrate the need for regulating confined space entry. In 1993, OSHA published the rule 29 CFR 1910.146 which promulgated the safety requirements (including a permit system) for entry into "Permit-Required Confined Spaces." This standard provides a comprehensive regulatory framework within which employers can effectively protect employees who work in hazardous confined spaces.

What is a Confined Space?

A confined space has these characteristics:

- enough room for entry,
- limited openings for entry or exit, and
- is not designed for continuous occupancy.

Some confined spaces have, in addition, potentially hazardous atmospheres (asphyxiating, flammable, or toxic) or conditions where engulfment, entrapment, or other

serious safety or health hazards may exist or develop. In these cases, entry into the space requires careful planning and extensive precautions. These spaces are known as permit-required confined spaces in which your supervisor has specific obligations under the law.

Safety Requirements for Working in a Permit-Required Confined Space

To prevent accidental deaths and injuries resulting from work in confined spaces, your supervisor must organize a confined space entry program. Your supervisor is required to take the following steps to control permit-required confined space (permit space) hazards:

- Identify permit spaces in your area. This will require a posted danger sign as follows:

"DANGER — PERMIT-REQUIRED CONFINED SPACE — DO NOT ENTER."

- Develop and use a written permit space policy, including permit system and emergency procedures.
- Document procedures when a permit is not required.
- Prevent unauthorized entry into permit spaces (i.e., lock it up when not in use).
- Evaluate hazards and conduct entry preparation.
- Supply protective equipment.
- Maintain and review the program.

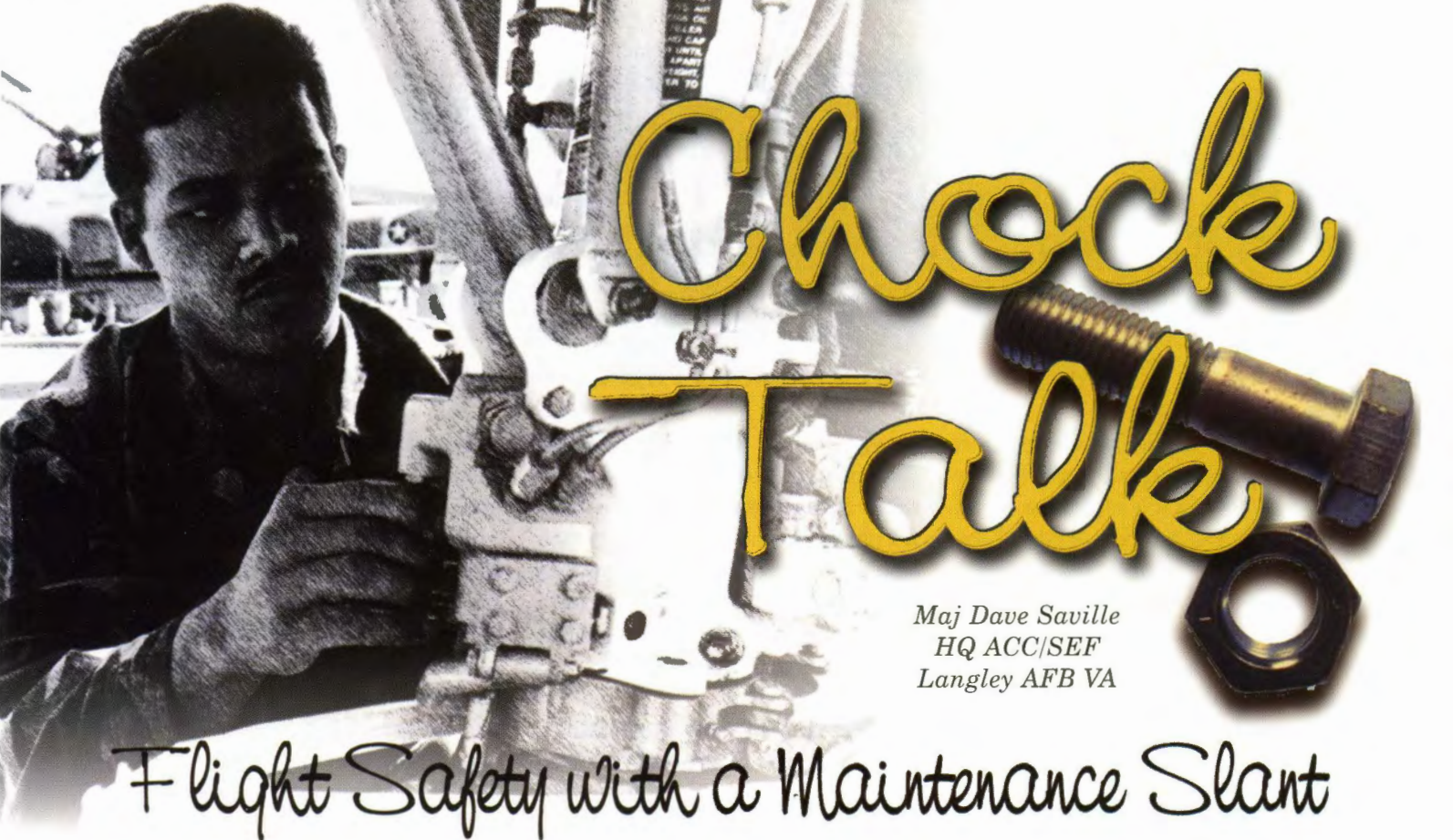
The written program your supervisor develops prevents unau-

thorized entry into permit spaces, identifies and evaluates confined spaces, and establishes procedures and practices for safe entry. Under the program, your supervisor must provide you necessary equipment when you enter a permit space, have an attendant stationed outside the permit space during entry, establish procedures to summon rescuers and prevent unauthorized personnel from attempting rescue operations.

Your supervisor must design and use a system for preparing, issuing, using, and canceling entry permits. In addition, he or she needs to formalize a procedure to handle coordinated entry of personnel into permit spaces when more than one person is involved. Once the permit program is in place, your supervisor should review it each year.

This standard covers almost 240,000 workplaces employing 12.2 million workers. Workers enter about 4.8 million permit spaces each year. Compliance with the provisions of the OSHA standard will effectively protect employees who work in permit-required confined spaces from injury or death. OSHA estimates that the standard will prevent over 50 fatalities annually associated with confined space entry. ■

Note: For Air Force specific requirements, refer to AFOSH Standard 91-25, Confined Spaces.



Chock Talk

Maj Dave Saville
HQ ACC/SEF
Langley AFB VA

Flight Safety with a Maintenance Slant

Pass it On

Maintaining a
safety
bulletin board
is simply not
good enough.

With the ever-decreasing average skill level in the aircraft maintenance arena, we are all challenged to maintain the capacity to safely generate sorties. Whether we lose skill level authorizations, manning slots, or spare parts, every year seems to bring compounded challenges to get the job done right. That is to say, to get the job done "safely." The single word that captures this commodity (and we seem to be losing more and more of) is "experience." Many experienced men and women leave the Air Force, and younger troops are left with responsibilities traditionally handled above their pay grade. The remarkable thing is that, for the most part, maintainers continue to rise to that challenge... in spite of the circum-

stances. I do believe, however, that we could manage these challenges better by emphasizing one supervisory skill more than we currently do... and that is "passing safety lessons learned on to others."

Finding effective and consistent ways to pass on the safety lessons we learn could greatly enhance our ability to avoid costly and tragic mishaps, as well as maintain our capacity to fly and fight. **Maintaining a safety bulletin board is simply not good enough.** As supervisors, we must structure our time to consistently work this priority. We must take the most important safety lessons learned and effectively pass them on. In this month's Chock Talk article, I want to share a maintenance story with

you and how I could have done better at this leadership skill if I could go back and do it over. I hope you will be encouraged to review, and perhaps revise, how you would handle a similar circumstance.

I remember well this particular time in my aircraft maintenance career in which I could have done a better job at "passing it on." It involved an F-15 that liked to slowly roll over in flight every once in a while, without the pilot asking it to. So, we impounded the aircraft to solve this problem... once and for all. The problem was intermittent and elusive, but a very talented member of our team finally figured it out. The actuator for the heat exchanger bypass door, which opens and closes at Mach 0.8, was broken off its anchor and occasionally pushed a flight control bell crank, causing the left aileron to deflect into the air stream. The Technical Order (T.O.) never told us to consider that. Experience was the only thing that led us to properly identify the problem.

To an F-15 maintainer, this was a tremendous find! When it comes to systems like avionics and flight controls, we rarely have the pleasure of finding what's called a "hard break." Normally, we can't find the cause of the flight control problem and are forced to swap out several parts to tackle the most probable culprit. If the problem went away, we were successful. But in this case, we found the hard break. I was so excited — I told everyone about it. I wanted to ensure that if this anomaly was to ever recur in another F-15, we'd all know the first place to look after the T.O.'s fault isolation trees were exhausted.

We considered both adding an inspection of this actuator bracket

to our 200-hour phase inspections and a one-time inspection of the squadron's aircraft. Now that it is a couple of years later, however, I wish I had done more. Each one of these maintenance problems has clear flight safety implications and should be shared with the entire fleet. If I could go back in time, here's what I'd do differently:

1. I would fully brief the nearest Air Force Engineering and Technical Service (AFETS) technician. Normally they are on your base and would have been involved in the troubleshooting; but with composite wings and multi-MDS fighter wings, that is not always true. Our local AFETS rep was an A-10 guy. The nearest F-15 AFETS rep was at another USAFE base. Wherever they are, they tend to have more longevity than active duty military and can handle the corporate memory a little better.

2. I would have written a safety crosstell message and had the wing safety office transmit it to the F-15 community. This is often how engineers at the aircraft system's manufacturing contractor (e.g., Lockheed-Martin, Boeing, etc.) get information like this, and they can be very helpful if you tell them the problem.

3. I would tell all of my maintainers to eyeball the break, so they could add it to their bag of experiences. Likewise, every maintenance unit should have a Maintenance Information File (MIF) in which all maintainers must read and sign off on several quality assurance, ground safety, and flight safety crosstells. If my particular F-15 situation didn't affect the rest of the wing, I could still create a separate squadron section in the MIF and

get all of my people to read it.

4. I would have made it a briefing item for all roll calls. I would also consider using other people's maintenance safety crosstells, mishap reports, and *The Combat Edge* articles in my safety briefing program.

5. I would have written an article for the MAJCOM safety magazine (like *The Combat Edge*) or an equivalent periodical that reaches the target audience. (Note: Call the guy writing the *Chock Talk* column {Hey! That's me!}, and he'll certainly find a way to get your crosstell going.) Furthermore, I would have nominated the maintainer that fixed the jet for a MAJCOM level safety award. It's a super way to get him or her the deserved recognition while at the same time getting the safety story out to people.

By not passing on this "lesson learned" very effectively, I missed several opportunities to fight the experience problem in our maintenance population. There are hundreds of these type events occurring throughout the Air Force on a daily basis, so there are plenty of opportunities. Hopefully, this article encourages you to "pass it on" more in your unit and beyond. Oh, yeah... and by the way, now's a great time to ask you to send me your inputs for this monthly *Chock Talk* column. Please e-mail me at david.saville@langley.af.mil, or call me at DSN 574-8816. I'd love to help you share your "maintenance lessons learned" with your peers and chat with you about your idea(s) for the column. ■

Annual FY99 ACC Awards



COMMANDER'S AWARD FOR SAFETY

9th Air Force/USCENTAF
Shaw AFB SC



SAFETY SUSTAINED SUPERIOR PERFORMANCE AWARD

TSgt Brook Morris
3 CCG
Tinker AFB OK



SAFETY OFFICE OF THE YEAR AWARD - CATEGORY I

27 FW
Cannon AFB NM



SAFETY OFFICE OF THE YEAR AWARD - CATEGORY II

53 WG
Eglin AFB FL



DISTINGUISHED CHIEF OF SAFETY AWARD

Lt Col (Sel) Ronald Dorn
53 WG
Eglin AFB FL



DISTINGUISHED PILOT SAFETY AWARD

Maj Jack Hirrlinger
99 RS, 9 RW
Beale AFB CA



DISTINGUISHED AIRCREW SAFETY AWARD

Capt David Serage, Lt Mitch Hayes,
Lt Chris Carbone, Lt Jake Garcia
Det 1, 366 OG
NAS Whidbey Island WA



OUTSTANDING ACHIEVEMENT SAFETY AWARD

3 CCG
Tinker AFB OK

27 FW
Cannon AFB NM



DISTINGUISHED FLIGHT SAFETY OFFICER AWARD

Capt Alexis Franco
20 FS, 49 FW
Holloman AFB NM



DISTINGUISHED FLIGHT SAFETY NCO AWARD

TSgt Thomas Lyman
1 FW
Langley AFB VA

DISTINGUISHED CREW CHIEF OF THE YEAR AWARD

SSgt Carson Smith
95 RS, 55 WG
Offutt AFB NE
(Photo unavailable)



DISTINGUISHED FLIGHT LINE SAFETY ACHIEVEMENT AWARD

SSgt Richard Rodriguez
33 MXS, 33 FW
Eglin AFB FL



DISTINGUISHED GROUND SAFETY ACHIEVEMENT AWARD

SSgt Donald Prescott
65 TRNS, 65 ABW
Lajes Field, Azores



EXCEPTIONAL GROUND SAFETY LEADERSHIP AWARD

Mr. George Foreman
53 WG
Eglin AFB FL



SUPERIOR PERFORMER IN GROUND SAFETY

TSgt Brook Morris
3 CCG
Tinker AFB OK



CMSGT PAUL A. PALOMBO AWARD FOR DISTINGUISHED GROUND SAFETY NEWCOMER

SSgt David Sharon
355 WG
Davis-Monthan AFB AZ



ANNUAL UNIT GROUND SAFETY AWARD - CATEGORY I

55 WG
Offutt AFB NE



ANNUAL UNIT GROUND SAFETY AWARD - CATEGORY II

3 CCG
Tinker AFB OK



ANNUAL TRAFFIC SAFETY AWARD - CATEGORY I

4 FW
Seymour Johnson AFB NC



ANNUAL TRAFFIC SAFETY AWARD - CATEGORY II

53 WG
Eglin AFB FL



EXCEPTIONAL WEAPONS SAFETY INDIVIDUAL AWARD

Mr. Brian Tripp
509 BW
Whiteman AFB MO



DISTINGUISHED WEAPONS SAFETY ACHIEVEMENT AWARD

SSgt Jonathon Hanson
83 FWS
Tyndall AFB FL



OUTSTANDING UNIT WEAPONS SAFETY AWARD - CATEGORY I

1 FW
Langley AFB VA



OUTSTANDING UNIT WEAPONS SAFETY AWARD - CATEGORY II

33 FW
Eglin AFB FL

The Lingering Pain of Suicide

I wonder how many friends and strangers I see every day who have thought of suicide at least once in their lives.

Whether things at home or at work are slowly getting the best of you and you think that life isn't worth living anymore, think again!! There is a solution! And if you reach out and ask for help, I assure you... people who really care will be there with help and guidance.

My husband took his own life over 5 years ago. At times, it seems like yesterday. Then at other times, it seems like a lifetime ago. I still miss him so very much. A day does not go by that I don't think about him or speak of him to my family and friends. If only I had been aware of the warning signs before it was too late.

If you see a family member, friend, or co-worker on a regular basis, and they seem depressed or quieter than usual, display mood swings or an attitude change, increase their alcohol intake or express foul language, please tell someone who can help.

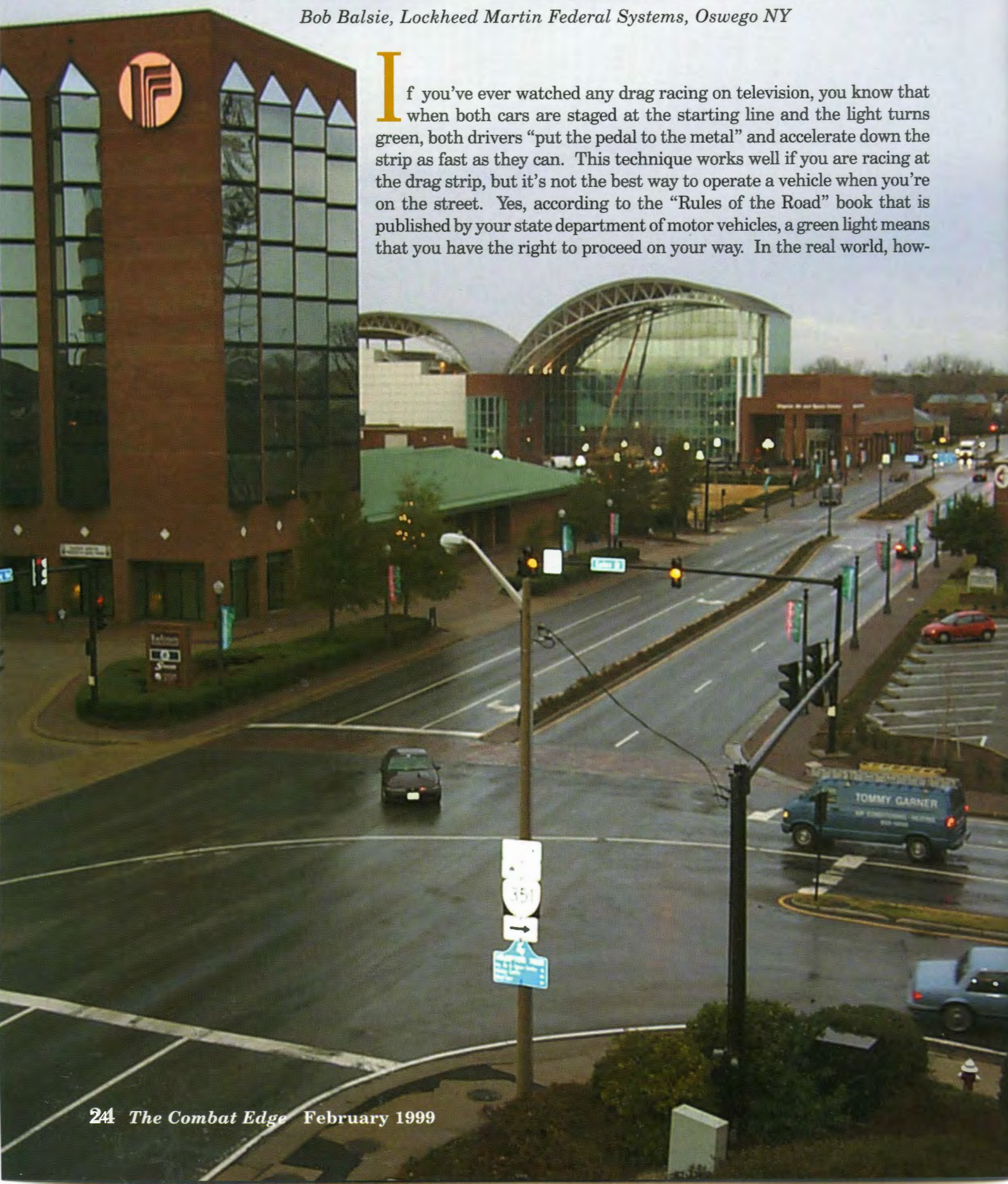
Believe it or not, suicide is a very selfish act. When someone commits suicide, any suffering they were experiencing on earth is now over. However, the survivor's suffering is just beginning; and believe me — it lasts a lifetime.

*Mrs. Keele Santiago
Air Force Widow*

Just to Make Sure

Bob Balsie, Lockheed Martin Federal Systems, Oswego NY

If you've ever watched any drag racing on television, you know that when both cars are staged at the starting line and the light turns green, both drivers "put the pedal to the metal" and accelerate down the strip as fast as they can. This technique works well if you are racing at the drag strip, but it's not the best way to operate a vehicle when you're on the street. Yes, according to the "Rules of the Road" book that is published by your state department of motor vehicles, a green light means that you have the right to proceed on your way. In the real world, how-



ever, simply using the green light as your only criteria for proceeding ahead can get you into serious trouble.

Back in 1976, about a month after my wife and I were married, we decided to take a drive early one Saturday morning in November. I was driving my '71 Javelin with the big-block motor. It was cold that morning; and that big chunk of Detroit iron under the hood was still cold when we pulled up to a traffic light about 3 blocks from our house. When the light turned green, I let the clutch out a little too fast; and because the motor wasn't warmed up well, the engine died. I reached up to turn the key to restart; and just as the engine was coming to life, a car came flying through the red light from right to left. It appeared to be going much faster than the 30 mile per hour speed limit; and whether the lady who was driving didn't see the light because the sun was in her eyes — or because she was thinking about something else — I don't know. It was obvious to me, however, that she could have caused an accident.

It wasn't until later that I really sat down and visualized what could have happened. If the engine in my car had not died, we would have been in the middle of the intersection when the other car ran the light. We would have been struck broadside, and my wife could have been killed instantly — while I could have suffered serious injuries. The lady driving the other car would probably have been killed or seriously injured, as well. Sure, we had the green light; but if the circumstances had been slightly different, it would have been a green light to the Promised Land for some of us.

This kind of mishap isn't limited to traffic lights either. A stop sign at an intersection can also set the scene for disaster. One other morning while driving to work, I stopped at a stop sign at a "T" intersection. Because it was early, there was a lot of traffic; and I was anxious to make my left turn onto the main road. Traffic was clear to the left. But on my right, a lady was approaching me who had her left turn signal flashing. Apparently, she was planning to turn onto the road that I was on; so it seemed logical that I could quickly pull out and be on the main road before she made her turn. Still, I decided to wait... "just to make sure"; and it's a good thing I did! She didn't turn onto the road that I was on. She went straight on past it and made her left turn into a gas station that was adjacent to the intersection. Had I pulled out, at best there would have been the screeching of tires and angry words directed my way. At worst, there would have been crushed metal and physical injury... and it would have been MY FAULT!

You never can accurately deduce what other drivers are thinking or predict what they are going to do. Sometimes, even THEY don't know what they're going to do! A case in point was another occurrence at a different stop sign just about a block from our house. My wife and I were going on a short trip in the afternoon, and we stopped near the stop sign — a "T" intersection — at the end of our street. I looked left and saw a car coming toward us. His right turn signal was flashing, he was slowing down, and he was even starting to swing the front of his car toward the street we were on. There was no other place he could turn into if he wanted to, so it was obvious to me that the way to the

left was clear. I then turned to look to the right to check for bicycles, pedestrians, etc.; and seeing none, my first impulse was to go ahead and make my right turn. But something told me to look left again... "just to make sure." I started to turn my head to the left and was shocked to see the other car RIGHT IN FRONT OF ME — JUST A FEW FEET AWAY! Apparently, he had changed his mind about making the turn at the last second and was swinging back into his lane again. If I had simply pulled out into the street, he would have taken the front end off of our car and smashed the front end of his... and as before, it would have been MY FAULT!

I've had other experiences like this that I could relate, but I'm sure you get the idea. The bottom line is... when you are driving your car, you should never take anything for granted. You must always assume that other drivers are going to make mistakes or do things that will put you and your family or friends in jeopardy. This means that you need to devote your complete attention to driving your vehicle. You can't drive while you shuffle through a stack of CDs looking for some music to match your mood. You can't "window shop" while driving through the business district. You can't drive while looking toward the back seat to arbitrate an argument between your kids. And above all, you can never assume that just because you are following all of the "Rules of the Road" that your safety is assured.

On the drag strip, "Green means go." Everywhere else, green means "take another look... **just to make sure.**" ■









Fleagle



Flight Safety Stats

ACC & ACC-Gained Losses for FY 99

1 Oct 98 - 5 Jan 99
Class A Damaged or Destroyed Aircraft

| | |
|-----------------------|--|
| 8 AF |  |
| 9 AF |  |
| 12 AF |    |
| AWFC |  |
| CANG |  |
| CAFR | None |
| Aircrew Fatalities |  |

Class A - Fatality; Permanent Total Disability; Property Damage \geq \$1,000,000

* Non-rate producing

1998 Survey Results

"Bring back 'Chock Talk' or some other form of flight line safety article for passing on maintenance lessons learned."

You asked for it! You Got It!

In our August 1998 issue, we asked you to participate in a survey so we could measure how well we're meeting your needs as a customer. We need your inputs to improve *The Combat Edge* and better serve you. To all the people who took the time to send us their opinions, THANK YOU. We enjoyed reading your thoughts (yes, we read every survey) and appreciate your honesty.

Again, thanks to everyone who filled out a survey and now ... how about an article? You can help make *The Combat Edge* better and correct the shortfalls you identified by sharing your experiences and expertise with your fellow readers. We are completely dependent on YOUR articles.

The Staff of The Combat Edge

Survey Comments from our Readers:

- "ORM column is great!"
- "... consider publishing more information directed towards ACC's gained units in Air Force Reserve Command."
- "Bring back 'Chock Talk' or some other form of flight line safety article for passing on maintenance lessons learned."
- "Print more articles concerning Aerospace Ground Equipment (A.G.E.)"
- "Keep the balance... something for everyone is better than being too focused."
- "Excellent as is."
- "Continue to print more actual examples of ORM use and other safety lessons learned. Experience is the best teacher."
- "Print less of the corny cartoons."
- "You're doing good."
- "Less pomp."
- "I would like to see more on the investigative side."

Did You Know...

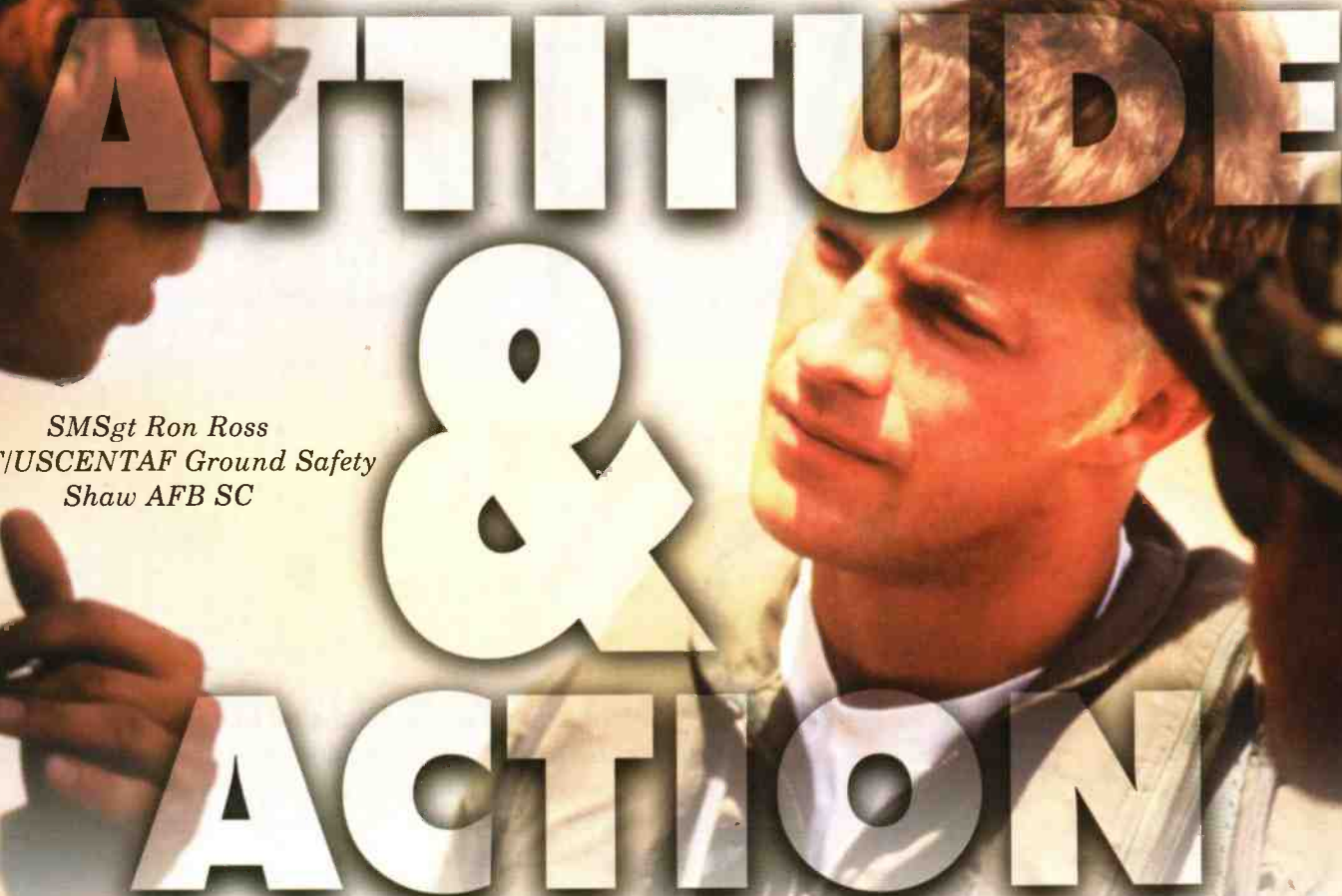
... cooking equipment is estimated to be associated with more than 100,000 fires annually, almost 400 deaths, and 5,000 injuries? Gas cooking equipment accounts for about 30,000 fires and electric cooking equipment for about 55,000 fires.

Here is a simple survey to take on cooking safety. You should be able to respond "yes" to all of the following:

- Is the storage area above your stove free of flammable and combustible items?
- Do you wear short or tight-fitting sleeves (as well as tight-fitting shirts, robes, gowns, etc.) while cooking?
- Do you store items that attract children (e.g., candy and cookies) away from the storage area above the stove (i.e., separate from the immediate cooking area)?
- Do you ensure your stove is not left unattended when cooking... especially when the burner is turned to a high setting?

If you were not able to respond with a "yes" to the above questions, here are some additional recommendations to help keep your kitchen operating safely.

- Never place or store pot holders, plastic utensils, towels, or other non-cooking equipment on, above, or near the stove — these items can catch on fire.
- Roll up (or fasten) long, loose sleeves with pins or elastic bands while cooking. Do not reach across a stove while cooking. Long, loose sleeves are more likely to catch on fire than are short sleeves. Long, loose sleeves are also more apt to catch on pot handles — thereby overturning pots and pans and causing possible burns and/or scalds to the skin.
- Do not place items that attract children over the top of or near the oven range. This will reduce the attraction children may have for climbing on cooking equipment, thus reducing the possibility of their clothing catching on fire.
- Keep a constant watch on any cooking equipment that is required to be turned above the "keep warm" setting.



ATTITUDE & ACTION

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An enormous task facing today's Air Force supervisors in terms of manpower and mission accomplishment is attaining maximum mishap prevention performance from its most precious resource — people. Successful mishap prevention training during peacetime may well be the decisive edge in achieving combat readiness and warfighting superiority. A supervisor plays a most important role in this process as he holds the responsibility to groom and mold his personnel's ability to perform the Air Force mission in a safe manner. A supervisor who neglects safety rules, whether in word or deed, is teaching his troops that it's all right to ignore those established rules. We cannot tolerate such an attitude among Air Force supervisors. Supervisors need to teach their personnel the importance of the safety mission through their own attitude and action. Let's take a look at some approaches to safety supervision by

highlighting the more effective ways supervisors can encourage troop support for mishap prevention.

"Do as I say AND as I do!"

First of all, don't talk the talk if you don't walk the walk! Many supervisors have been called hypocrites by subordinates for verbally promoting safety policies which they themselves do not uphold. It often bothered me as a young troop when I observed the same supervisors and commanders who aggressively discouraged DUIs verbally at commanders call to be the first ones to go from the bar to their car after indulging at the club. "The do as I say and not as I do," mentality doesn't wash very well with today's bright and observant airmen. It just sends the wrong message — a message of confusion — which ultimately results in a less than adequate safety posture among subordinates. A truly safety-minded leader mentors by word and supports his safety stance by example. A su-

pervisor is to be a living example to his troops that his behavior reflects his spoken words.

Personal Relationships and Professional Performance

Secondly, do not let your personal relationship with your troops interfere with professional performance. It's human to be friends with a subordinate, but it's not a very natural response for some supervisors to put professionalism before personal friendship. One must separate the two. As a young supervisor, I had to make a decision in this area; and I'd like to think I decided in the best interest of the AF. I was a supervisor responsible for the safe operation of a million dollar firefighting vehicle and my crew of three personnel. We had just begun our shift at 0700. As my crew members were conducting an operations check of the vehicle, I smelled a very strong odor of alcohol on my assigned driver's breath. The driver, with whom I was a close

friend, seemed very fatigued and irritated. After noticing a less than adequate behavior from the driver, I inquired if everything was all right. The driver responded, "Yeah!" It was obvious that this troop was still suffering from a very late night of indulgence, but this time it was on my watch and it was at our expense! I wasn't about to leave things as they were; it was too risky. Lives were in danger; and not just mine or those of my crew, but the entire base populace... which counted on our firefighting capability. I approached the driver's immediate supervisor to resolve the matter. However, I knew it would drastically change the relationship I had previously shared with my driver. To make a long story short, the driver was sent to the hospital and was found to be legally intoxicated. I lost a friend but gained a lot of respect from my supervisors and peers who supported my actions. It wasn't an easy decision and did not come without some thought. I realized that this troop had hurt himself and was responsible for his own demise. A supervisor must be an advocate for safety, have the courage and backbone to support mishap prevention, and never compromise sound judgment for the sake of personal relationships.

Safety and Your People

Thirdly, stand up for safety — protect your people. While TDY to a remote overseas site, I was the crew chief of a crash rescue response effort. We provided support for all United States aircraft frequenting the base. It was a feast or famine duty as there were no American aircraft permanently assigned. However, we were on standby everyday around the clock. My commanding officer saw my crew as manpower with too much free time and decided to use my crew to demolish several dilapidated base facilities. We were given two crowbars along with a sledgehammer and told to tear down the interior wall structures. No training was provided, and no pre-

cautions were given. It was explained to us, however, that we had to strike the wall structure first and then pull off the existing layers of wood and sheetrock.

As we took to the task, we noticed that radiant electrical sparks would fly out from behind the walls as we struck them. A closer look at the walls revealed live electrical wires ran throughout all the facilities. I ordered my crew to stop work until we could kill the power. I immediately contacted the local national electrical personnel and asked that the power be shut down to the facilities. In response to my request, I was informed that it was impossible to isolate the power. To my amazement, the electrical personnel claimed the buildings were designed this way. They said it was safe to continue on with our tasking, there was no inherent hazard, and they had already demolished other buildings like ours in the same manner. I later found out that numerous firefighters before me assigned to do this exact same task conducted the task without complaint.


I called my home station to talk to my supervisor about the task. After explaining it all to him, he said he couldn't help me since I was under the authority of the commanding officer. I was a safety-minded crew chief who constantly stressed safety to all my crew, and now I was leading them on one of the most unsafe duties of our tour. The next morning I approached the commanding officer who was a former special forces commander who had served in "Nam." I really didn't care to face him, but I knew we were placed in an unsafe environment and fearful for our lives. Unfortunately, there was no safety office on the base that I could consult. I calmly explained our plight to the commanding officer, and he reluctantly agreed that we shouldn't continue with the task. After our conversation, it appeared to me that he knew how dangerous the task was, but he was more con-

cerned about getting the job done than the welfare of my crew. My troops were very appreciative of my "Attitude and Action" because I stood up for their safety.

The Moral to the Story

The moral to this story is very clear— don't put your subordinates in a compromising safety situation. Don't allow yourself or subordinates to do things that you believe are unsafe, even if someone before you set their own precedence for safety. In addition, don't have your people perform a task that they're not trained to conduct. If they are not qualified to perform it, then don't encourage or coerce them to do so. Furthermore, if your troops request your assistance on a safety matter, get involved and help them the best you can. If nothing else, at least contact the safety professionals for advice.

A supervisor has a responsibility to provide a safe and healthful work environment to subordinates. Through "Attitude and Action," supervisors demonstrate to subordinates that their safety is important and establish safety as an important objective for each person under his/her care. Supervisors play a key role in determining the effectiveness of the Air Force Mishap Prevention Program by preparing their troops for safe performance. The supervisor's emphasis on safety awareness will not stifle initiative but rather instill a sense of confidence for an expected outcome in most activities (i.e., if a person follows established procedures, it is a means to an end). Through emphasis on safety awareness, the supervisor indicates that each member or property asset is important to the Air Force team and its mission. As supervisors, we have an obligation to protect each Air Force member and the equipment they employ for successful mission accomplishment. "Attitude and Action" are key to preserving our combat dominance — never lose sight of this; it's your responsibility. ■



Dr. Guion S. "Guy" Bluford
First African-American Astronaut

General Daniel "Chappie" Jones
First African-American Four-Star General

Major General Marcelite J. Harris
First African-American Female General

Bessie Coleman
First Female African-American Aviator

The first graduating class of African-American pilots
in the history of the US Army Air Corps
from the Advanced Flying School, Tuskegee AL

General Benjamin O. Davis, Jr.
First African-American
Air Force General Officer