

Spring Edition 2014

Combat Edge



ACC's Full-Spectrum

Safety Magazine

A full-page background image of a motorcyclist wearing a brown leather jacket and a clear helmet, riding a motorcycle on a road. The sun is low in the sky, creating a strong orange glow and lens flare effect.

**WHY
RIDERS
DIE ...**

PAGE 12

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4 | COMPLACENCY ... A SILENT KILLER

by Maj. Hector L. Collazo III
1 SOW Flight Safety, Hurlburt Fld, Fla.

8 | THE PURSUIT OF PERFECTION ...

by Capt. Ryan R. Landoll, Ph.D.
20 MDOS/SGOW, Shaw AFB, S.C.

12 | WHY RIDERS DIE ...

by Col. J. Alan Marshall, Ph.D.
HQ ACC/SE, Joint Base Langley-Eustis, Va.

Combat Edge

Volume 22 Issue 4, ACC SP 91-1

18 | MONTHLY AWARDS

20 | QUARTERLY AWARDS

21 | STATS

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ACCent



Know when to “Knock-it-Off”

As we enter a new year, the great efforts and capabilities of Air Combat Command’s personnel continue to ensure our Air Force remains the world’s greatest air power to support our nation’s defense. On the flying side, we passed through a challenging period of reduced flying hours and are now entering a time when we need to ensure we’re staying on top of the ops tempo caused by now-available flying hours and sorties.

In our fall 2013 issue, ACC’s Vice Commander, Lt. Gen. Lori Robinson discussed the risks inherent with ramping up to Combat Mission Ready status in a short time. Now, we need to ensure we’re staying focused on risks and issues inherent with a continuous, on-going operations rhythm.

These risks and issues are nothing new. You’ve heard them before—fatigue, complacency, lack of planning, as well as others. Being aware of the risks is important—understanding how to mitigate them is also critical. Focused, engaged leadership and ensuring effective operational risk management in all facets of unit and individual actions are essential, from building the weekly flying schedule to adjusting missions for weather and personnel issues.

Another aspect both individuals and unit leadership should always highlight is the ability to call a “knock-it-off” when necessary. As we are all aware, most mishaps are usually comprised of a chain of events, which is always evident when reviewing mishap investigation reports and gaining insight into the causes. Viewed independently, any one portion of the mishap “chain” is often a fairly benign event, but if a knock-it-off call would have occurred to alter or cease an action during the seemingly innocuous event, the final outcome would likely have changed for the better.

While none of us can accurately predict the future, we all have training and experience which guides our decisions and actions, directly shaping future situations. This is where a proper “knock-it-off” is critical—especially when events, planned or unplanned, are rapidly changing or emerging.

If your training and experience is telling you there is an issue, a “knock-it-off” call may be in order. Getting the mission done is always important and a top priority, but keep in mind pressing too far can end the mission before it is complete, as well as adversely impact future missions if it causes a loss of an aircraft or crew. Obviously, this is not the mission result anyone desires. Properly utilized, risk management, combined with a unit culture which knows when to “knock-it-off” actually enhances mission effectiveness and capabilities.

Keep up the great efforts and fly safe!



Col. Lawrence A. Nixon
Chief of Flight Safety

Complacency

A Silent Killer

BY MAJ. HECTOR L. COLLAZO III

Just in Fiscal Year 2012 (FY12)¹, complacency as a causal or contributory human factor accounted for only one percent of the total reportable safety mishaps, but represented 30 percent of the total Class A mishaps, 41 percent of the total cost, 50 percent of the aircraft destroyed, and 56 percent of the fatalities.

That gives “complacency” a price tag of \$236.7 million and five service members that paid the price in blood ... and that doesn’t even include the near misses!

When assessing risk or employing Risk Management (RM) principles, every commander, operations officer, planner, and aircraft commander reviews the tasked mission, whether training or actual, and tries their best to identify the top risks and mitigate them. For some of our more routine activities, identifying risk can be difficult and sometimes ignored. In these instances, “complacency” can sometimes become the RM form’s scapegoat when the Aircraft Commander “pencil whips” it in as a high risk item without giving it much thought. Challenging this as a valid high risk for a particular mission’s RM is easy and justified, but more often than not complacency is in fact the highest risk for the mission and if left unchecked, the source of the next mishap.





Photo by: Staff Sgt. Alexandre Montes

Almost every mishap can trace its origins in human factors. “Complacency is a factor when the individual’s state of reduced conscious attention due to an attitude of overconfidence, undermotivation or the sense that others “have the situation under control” leads to an unsafe situation.”² Unaware of actual danger, the victim of complacency may even feel a sense of self-satisfaction. This can affect aircrew or maintainers as both professions look toward proficiency in certain tasks. As the individual develops proficiency, overconfidence may mask their awareness of danger.³

The Federal Aviation Administration (FAA) lumps “complacency” into a top 12 list of common causes of human factors errors, affectionately known as “The Dirty Dozen.”⁴ In fact, “complacency” sits in the #2 seat behind “Lack of Communication.” This is a common problem for both aircrew and maintainers alike.

Some symptoms of complacency that we all should be wary of include:⁵

- 1) Accepting lower standards of performance,
- 2) Erosion of desire to remain proficient,
- 3) Boredom and inattention,
- 4) Satisfied with the status quo,
- 5) Increased feeling of well being, and
- 6) Neglecting personal safety items.



Photo by: Senior Airman Timothy Taylor

There are five major types of complacency that can result from these symptoms:⁶

1) Task Induced:

Task induced complacency can be found in task saturated environments or events. Examples can be seen during high operations tempo periods such as readiness exercises, or even during brief periods where multiple external influences are bearing down such as heavy traffic in the visual pattern at night.

2) Organization Induced:

Organization induced complacency is where supervisors and leaders play a role. By accepting shortcuts or not holding subordinates accountable, an organizational culture of complacency can be promoted.

3) Fatigue/Stress Induced:

Fatigue and stress induced complacency is almost self explanatory. After multiple visual approaches to touch-n-go’s, a checklist item or the entire checklist may be missed as the training events become mundane. At best, the crew catches the deviation in time and executes a go-around.

4) Dependency:

Dependency complacency focuses in on co-workers that you recognize as being proficient and dependable. Not only do you assume they will catch your mistakes, but you misplace confidence in them when they may be victim to the same type of complacency in yourself. Two experienced maintainers may rely on each other to accomplish all the steps on a given technical order checklist, only to later find out that the other assumed the same and did not accomplish all the steps.

5) Automation:

Automation is simply a reliance on technology. The catch with this one is that it’s the same technology that is designed to improve your situational awareness and promote safety. It breaks down to the individual being an operator rather than a supervisor of the technology. Not properly monitoring instrumentation in the cockpit because you assume the technology is always right might leave a computer malfunction unchecked.

Understanding the types of complacency and the symptoms that lead to them is the first step at mitigating complacency. In addition to recognizing these symptoms, the FAA suggests that aircrew and maintainers take a cautious approach. They suggest mitigating the risk of complacency by:⁷

- 1) Avoiding the tendency to see what you expect to see,
- 2) Expecting to find errors,
- 3) Not signing it if you didn’t do it,
- 4) Using checklists, and
- 5) Learning from the mistakes of others.

Consider two scenarios: 1) a highly complex night tactical training sortie with multiple students and training objectives, or 2) a simple basic preflight (BPO) of a line flying aircraft in a permissive environment. Which scenario would you consider complacency to be a top risk for the mission? Would you think both? An obvious answer may be the BPO with its ample opportunity for repetitive, monotonous, robotic, automation and fatigue induced complacency. But how about the high workload training line full of repetitive, monotonous, robotic, and fatigue/stress inducing checklists and training requirements compounded by repetitive tasks such as multiple approaches, landings, threat engagements, or extended low level? Add a little task induced complacency and you have equal opportunity for disaster caused by complacency on both accounts.

Complacency is not just an RM worksheet “scapegoat.” It’s a silent killer that directly caused or contributed to 44 percent of our safety mishaps in FY12 alone.⁸ It’s insidious and clandestine, either sneaking into your active risk mitigation where you catch it just in time for a “near miss,” or you miss it completely and fail to accomplish a checklist item on a repair or during a critical phase of flight. Now you have our next safety mishap. ✖



Photo by: Senior Airman John Nieves Camacho



Photo by: Airman 1st Class Jensen Stidham

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- ⁸ Air Force Safety Center. (2013). Op Cit.



the Pursuit of Perfection requires **BALANCE**

BY CAPT. RYAN R. LANDOLL, Ph.D.

We all know that eager young Airman who arrives fresh from officer training or tech school, eager to prove himself or herself to the unit in short order. They hit the ground running, picking up how to do things quickly, volunteering for as many activities as they possibly can, and striving for excellence in all that they do. The Air Force needs the energy and enthusiasm of these individuals, but we must also be vigilant of the risks of being “too perfect.” Take, for example, the story of Lt. Aces, who has just arrived at her first duty station after graduating from the Academy. She is eager to prove herself to her unit and to be noticed around the wing. She identifies a way to improve marketing for on-base activities through social networking. Her commander, impressed with her intellect, knowledge of subject matter and impeccable briefing skills, arranges for her to brief the wing commander, Col. Spades, about her proposal. Lt. Aces is excited for this opportunity, but knows that her brief must be “perfect.” She is used to staying up and pulling all-nighters from her days at the Academy. After all, this attitude and drive is what led her to graduate at the top of her class. So she thinks nothing of having to do the same thing in preparation for her brief.

Lt. Aces works through the day and night in the week leading up to her meeting with Col. Spades. Although her preparation takes up a lot of her time, she cannot bear to let any other obligations slip. So she maintains all of her volunteer activities, her intense PT workouts and all of her work obligations. Not only must this briefing be “perfect,” but so must everything else. Lt. Aces notices towards the end of the week she is more irritable than usual, exhausted from lack of sleep and has some difficulty concentrating. But that doesn’t matter. She is too focused on final preparations for her briefing. She re-doubles her effort, even skipping some occasional meals in order to make sure she has the time to dedicate to making sure that the final product will be ... “perfect.”



The day of the briefing, Lt. Aces arrives early in order to prepare. Although she is exhausted, mentally and physically, she downs a thermos full of coffee and reminds herself that she can sleep when her briefing is over. Col. Spades comes in and Lt. Aces delivers her brief. He is very impressed with her proposal and agrees that it is worth implementing. He suggests some minor changes and as he is leaving, suggests that Lt. Aces “gets some rest.” Lt. Aces’ commander comes over to congratulate her, noting that she handled her nerves “incredibly well.”

Although this would seem to be a great success and time for some much-needed rest, Lt. Aces finds

herself agonizing over the words from both her boss and Col. Spades. Was it that obvious how tired she was? Or how nervous she had been? Why hadn’t she already anticipated the concerns raised by Col. Spades and addressed those before he suggested them? Lt. Aces is incredibly distraught that, despite all her hard work, and her obvious success, the brief hadn’t gone off “perfectly.”

Due to budget restraints, Col. Spades has to delay the implementation of Lt. Aces’ marketing plan. Lt. Aces is certain it is because of some flaw in her presentation and the design of her marketing strategy. She is intensely ashamed that her plan has “failed.” Lt. Aces finds herself consumed by this shame. Her primary care doctor expresses his concerns to her when he sees her later that week, again encouraging her to get some much-

needed rest. But Lt. Aces is having difficulty sleeping, lying awake thinking about what she could have done differently to make her plan a success. Soon, she finds that she cannot take this distress anymore, and she takes her own life.

Suicide remains a significant threat to maintaining military readiness and keeping our Airmen safe. The story of Lt. Aces, while fictionalized, may remind you of some of your own troops. These individuals are hard-chargers, incredibly bright and successful, and the quality of their work makes them stand out amongst your unit. Yet, while all of us must seek to uphold “excellence in all that we do,” we must also be aware of the risks of a preoccupation with perfectionism and recognize warning signs in our Airmen who otherwise might be seen as the models of physical and psychological well-being.

Research has established links between perfectionism, shame, and suicide. In particular, socially prescribed perfectionism, or the belief less than perfect performance will result in a loss of approval from others whom are valued, has been consistently linked not only to suicidal ideation, but also suicide attempts (Flamenbaum and Holden, 2007). In part, this may be due to links between a perceived lack of perfection and shame, which has also been found to be a significant predictor of suicidal behavior (Wang, Wong, and Fu, 2013). Finally, the story of Lt. Aces underlies another important research finding—close to half of the individuals who complete suicide see a healthcare provider within a month prior to their suicide (Luoma, Martin, and Pearson, 2002). Thus, commanders, supervisors and healthcare providers all have an opportunity to intervene when they notice that an individual may be struggling. However, this requires them to recognize that some warning signs might not come from a depressed mood or affect or individuals who have experienced recent failure or loss. While these are also examples of behaviors commanders and supervisors should be vigilant of in their unit, it is also important that they recognize the potential risk of an individual who seems preoccupied and concerned with the pursuit of perfection.

Of course, this doesn’t mean that we cannot set high expectations for our Airmen. Indeed, the safety of our aircraft and our people require that we must. Nor does it mean that we should immediately become concerned when an individual appears to set high expectations and goals for oneself. In most cases, these shining stars in our unit will not only be successful, but will inspire others to perform well. It is important that commanders and supervisors encourage and develop the Air Force core values in all of our Airmen. However, it is also important that we recognize these warning signs amongst even our most high-achieving individuals.

It is also important we create a culture where our Airmen understand that making a mistake does not mean they will lose the approval of those around them to combat that concept of socially prescribed perfectionism. It is important that we encourage our Airmen to take care of themselves, recognizing that taking breaks is vital to ensure we have adequate physical and psychological energy to complete our mission. In fact, it may be helpful to know that taking occasional breaks is an important part of increasing overall efficiency and maintaining focus (Ariga and Lleras, 2011). Finally, we must strive to ensure that all Airmen understand that recognizing when they are struggling and speaking with a healthcare provider about their distress is a vital way to preserve our military readiness; understanding that this will not result in loss of approval by their chain of command.

The Air Force just recently released an update on their guide and management of suicidal behaviors for its mental health providers. As part of this update, commanders will be more aware and involved with individuals who may be dealing with elevated risk for suicide. While this has the potential to ensure that more communication exists to help an Airmen access needed treatment resources, it is also critical that commanders and supervisors work to identify those who may be at risk and ensure those individuals feel supported for recognizing their struggles and appropriately seeking help.

Being in pursuit of perfection can and will push us to achieve extraordinary things, but it is also important for us to recognize our own limits and reach out to others when needed. ✎

A close-up, low-angle shot of a motorcycle's front wheel and fender. The fender is a vibrant orange-red color, and the wheel is a polished chrome with a multi-spoke design. The background is a blurred, warm-toned surface, suggesting motion or a studio setting.

WHY RIDERS DIE ...

Qualitative Analysis of Air Force Motorcycle Fatalities

BY COL. J. ALAN MARSHALL, Ph.D.

Due to recent fatal motorcycle accidents in the command, the ACC Safety Directorate performed an in-depth analysis of Air Force motorcycle mishap records and found an interesting trend. Coupled with recent debates on the efficacy and expense of proposed additional mandates for motorcycle training, this trend sheds significant light on the issue. It is hoped that the following study description, results, and discussion will help supervisors, leaders and decision makers in their efforts to reduce fatal motorcycle accidents in the United States Air Force.

Review

In September 2013, the Air Force Chief of Staff (CSAF) presented Air Force Safety Center analysis to commanders that identified a significant trend in flight mishaps. Approximately 60 percent of Air Force flight mishaps during FY09 – FY13 occurred due to a lack of compliance with guidance or poor aircrew decision making.

The compliance and decision making factors were dominant among nine factors used to categorize five years worth of Air Force Class A flight mishaps. Less influential factors included: design, material, guidance, resource management, spatial disorientation, training, and weather. ACC Flight Safety expanded this research to analyze why each applicable ACC flight mishap was categorized as being the result of a lack of compliance.

Researchers found that only 8 percent of the flight Compliance mishaps were due to “willful non-compliance” whereas 39 percent of ACC flight mishaps were categorized as Compliance mishaps for causes that could reasonably be attributed to proficiency-related issues, and 53 percent of the Compliance mishaps were caused by all other issues combined. These results led ACC to tailor mishap prevention efforts to not only attack willful non-compliance issues, but also address other issues affecting safety such as aircrew proficiency concerns, and a needed re-invigoration of the overall safety enterprise.

Following the logic of this flight safety research, ACC Safety performed similar analysis on five year’s worth of motorcycle mishap data to search for related trends in Air Force fatal motorcycle accidents.¹ The primary research question was whether or not compliance with guidance played a significant role in Air Force motorcycle accident fatalities and if so, what specific non-compliance issues were dominant.

Methodology

Five years of Air Force fatal motorcycle mishap data (FY09 – FY13), comprised of 79 fatal motorcycle mishaps, were analyzed for causal trends using eight of the pre-determined factors from the previously discussed CSAF analysis of flight safety mishaps. In this qualitative analysis, each fatal motorcycle mishap was categorized by a panel of ground safety experts. The applicable causal labels were: compliance, decision making, design, material, guidance, resource management, training, and weather. Each expert panel member independently categorized each mishap by reading the entire safety investigation report including the causal findings. In the few instances where the panel did not have unanimous agreement, the panel voted with the majority determining the mishap causal categorization.

Initial results showed that failure to comply with guidance (Compliance) was the dominant factor and all other causes were relatively minor in comparison. Further analysis of the mishaps categorized as “Compliance” was then performed to identify whether member non-compliance was “willful non-compliance” or whether non-compliance was more of a unintentional nature. In mishaps categorized as Compliance mishaps, for reasons including speeding, reckless driving speeds in excess of 20 MPH above the posted speed limit were used as a criterion. This 20 MPH standard is a common benchmark for reckless driving citations in most states. If a motorcyclist had a mishap while traveling more than 20 MPH above posted speed limits, then the mishap was categorized as “willful non-compliance” due to excessive speeding. If the motorcyclist had the accident while riding above the posted speed limit, but less than 20 MPH above the posted speed limit, then the mishap was categorized as unintentional non-compliance with respect

to speed. A similar legal criterion was used for alcohol usage; if the rider had a blood alcohol level above the legal limit, then the mishap was categorized as “willful noncompliance,” whereas if the rider had alcohol in their blood, but the amount was below the legal limit, then the mishap was categorized as unintentional non-compliance with respect to intoxicants.

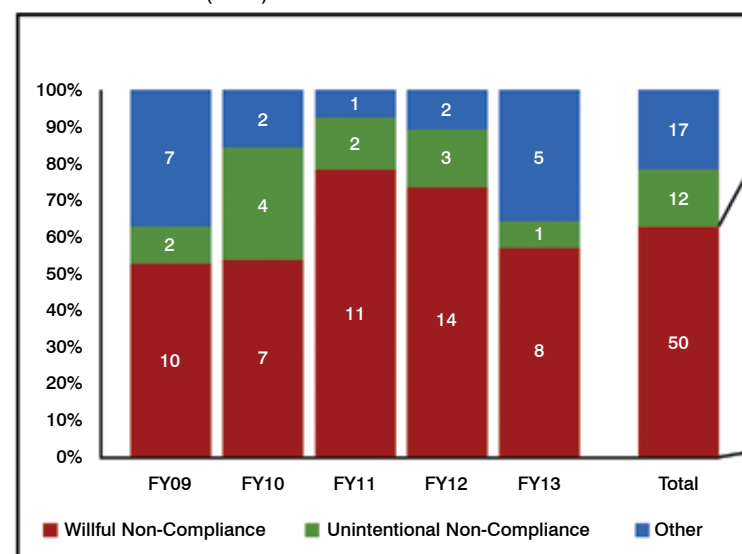
Motorcycle mishaps were categorized as “willful noncompliance” with respect to fatigue if the rider failed to follow Joint Travel Regulation restrictions for proper rest when driving/riding and mishaps were categorized as “willful non-compliance” for training if the member failed to perform all required training before riding at the time of the mishap. All other willful non-compliance reasons other than speeding, intoxicants, fatigue, and training had only one or two occurrences and thus did not represent trends. Note: the ability to generalize results in this research is limited by small sample sizes in individual years.



AF Fatal PMV2 Mishaps FY09 – FY13

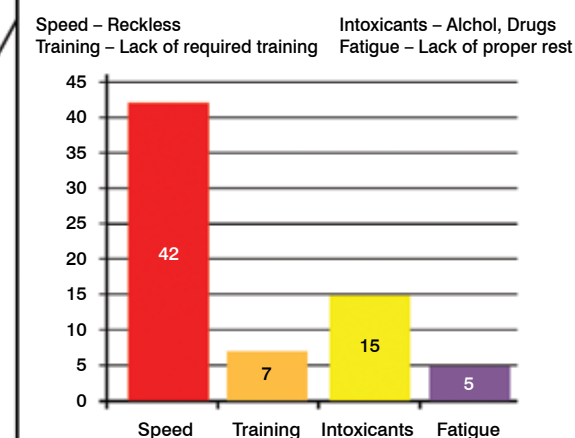
AF PMV2* Fatality Causal Factors

*(PMV2)—Two-wheeled Private Motor Vehicle



63% of all Fatal PMV2 mishaps involved willful non-compliance with guidance

Willful Non-Compliance Causes



Note: Of the 50 willful non-compliance mishaps, several involved more than one causal factor so the total number of factors add up to more than 50.

Speeding produces 6 times more negative effect than lack of required training

Figure 1

Results

Figure 1 shows that the overwhelming cause of the majority of Air Force fatal motorcycle mishaps from FY09 to FY13 involved failure to comply with guidance (78 percent or 62 of 79 incidents). Only 22 percent of the fatal accidents involved all other causes combined. The analysis also showed that 63 percent (50 of 79) of all fatal mishaps involved willful non-compliance with only 15 percent (12 of 79) involving unintentional non-compliance. Focusing on willful non-compliance, further analysis showed that 84 percent (42 of 50) of the fatal mishaps categorized as willful non-compliance mishaps involved excessive speeding (greater than 20 MPH above posted speed limits). The analysis also showed 30 percent (15 of 50) of the fatal mishaps categorized as willful non-compliance mishaps involved intoxicants (alcohol or drugs), 14 percent (7 of 50) involved a lack of required training, and 10 percent (5 of 50) involved fatigue. Since several of the 50 willful non-compliance mishaps involved more than one causal factor, the total number of factors added up to more than 50. For example, a motorcyclist could have been legally drunk, riding well beyond rest requirements, speeding at reckless driving speeds, and riding without any required training, so that the mishap would have involved speeding, intoxicants, training and fatigue, all at the same time.

These results imply that speeding represented nearly three times the negative effects of riding while intoxicated, eight times the negative effects of fatigue, and six times the negative effects of riding without required training.

Discussion

The results of this analysis should cause Air Force leaders to pause and consider mishap prevention strategies. This analysis shows that the overwhelming percentage of fatal Air Force motorcycle accidents involve excessive speeding. Although 20 MPH was used as the criterion for excessive speeding in this research, most of the motorcycle mishaps reviewed involved gross violations of speed laws—often 80 to 100 MPH over the posted speed limit. Compared with ACC flight mishap data where only eight percent of mishaps were found to involve willful non-compliance, Air Force fatal motorcycle mishap data showed that 63 percent of mishaps involved willful non-compliance. Similar ACC research has recently shown that 58 percent of Air Force fatal four wheeled mishaps over the FY09 to FY13 period involved willful non-compliance with guidance or laws.

These results should cause leaders to ask how the Air Force can better incorporate the same compliance and discipline culture in Airmen's off duty lives as they display on duty.

One approach may be for commanders to be on the lookout for indicators of the willingness of Airmen to speed excessively—especially gross violations. These results imply that riders who receive multiple speeding tickets or even one serious reckless driving speeding ticket (80 to 100 MPH over the posted speed limit) may be at high risk for a fatal motorcycle accident. ACC Safety has confirmed with ACC JA that such indicators may be used to identify high risk riders and commanders may act accordingly to limit or revoke riding privileges to save an Airman's life. Other indicators may be reports

from motorcycle mentor interactions or an Airmen's own words (i.e., social media). Commanders and supervisors should be alert for any information that identifies a particular motorcycle rider as high risk or a high speed rider, and should be prepared to intervene as appropriate.

Air Force decision makers should also consider macro-level motorcycle mishap prevention strategies. The results of this analysis may undermine the belief that the solution to the motorcycle mishap problem lies in increased mandatory training. This is especially true in an era of limited resources and shrinking budgets. This analysis implies that no amount of additional technical training will prevent fatal motorcycle accidents if Airmen have an attitudinal predisposition to ride their motorcycles at reckless driving speeds.

Training that involves weaving in and out of cones in a parking lot will not effectively reduce fatal mishap risks if Airmen intend on

simply complying with training requirements so they can later ride their motorcycle at 140 MPH the first chance they have to "wring it out."

More training emphasis should be placed on the dangers of high-speed riding and motorcycle mentors should be on the lookout for high-speed riders. Commanders must be willing to identify high speed riders and intervene by restricting or revoking riding privileges and higher level commanders must be willing to support these preventative actions. This analysis implies that high-speed motorcycle riding is the enemy, not necessarily motorcycle riding itself, and a concerted effort to identify and restrict high-speed riders may be the most effective way to reduce fatal mishaps. 🚩

Reference:

¹ Data extracted from the Air Force Safety Automated System (AFSAS)



AWARDS OF DISTINCTION

Aircrew Safety



CREW OF HAWK 83, 28 BS, DYESS AFB TX. The crew of Hawk 83 encountered 21 master caution lights and momentarily lost electrical power during a training sortie. The crew quickly analyzed the indications and determined they lost two of the four primary electrical buses. With degraded flight controls, flight instruments and fuel system transfer capability, the crew safely landed the aircraft due to outstanding CRM, airmanship, and systems knowledge. *(Awarded Nov. 2013)*

MAJ. CHAD T. ROGERS, CAPT. KEITH S. MADSEN, 75 EFS, BAGRAM AF, AFGHANISTAN. During combat operations in support of OEF, Maj. Rogers and Capt. Madsen displayed superior airmanship and teamwork while recovering an A-10C aircraft under dangerous conditions caused by a loss of cabin pressure coupled with a faulty regulator system. Their impeccable CRM enabled Capt. Madsen to navigate through Afghan terrain and flawlessly perform an extremely difficult instrument approach to a slick runway. *(Awarded Dec. 2013)*

CREW OF GNARL 12, 29 WS, LITTLE ROCK AFB AR. GNARL 12 departed Colorado Springs Airport and flew a low-level awareness training sortie followed by four assault landings. During the last landing, the crew noticed unusual bumps during roll out and while on takeoff roll they felt banging and heard noises from the left main wheel area. The crew analyzed the situation as a tire failure and expertly landed the aircraft at an unfamiliar field with differential thrust procedures to keep the aircraft on the runway. *(Awarded Jan. 2014)*

Pilot Safety



CAPTS. DANIEL S. MYERS AND MARSHALL K. BUCK, 75 EFS, BAGRAM AF, AFGHANISTAN. Capts. Myers and Buck skillfully and efficiently recovered a damaged A-10 aircraft during departure for a combat deployment. During the transatlantic leg, Capt. Myers encountered an abrupt loss of thrust from his left engine and quickly informed the flight lead, Capt. Buck. Utilizing superb CRM, the pilots' decision making, execution, and superior airmanship prevented a catastrophic mishap and further aircraft damage. *(Awarded Nov. 2013)*

2 LT. RYAN SABO, 357 FS, DAVIS-MONTHAN AFB AZ. Lt. Sabo's superior airmanship resulted in the safe recovery of his A-10C despite a left engine fire on his third flight ever in the aircraft. 2 Lt. Sabo's outstanding systems knowledge, checklist execution, crew coordination, and advanced airmanship directly contributed to the successful recovery of a \$13M A-10C aircraft. *(Awarded Dec. 2013)*

CAPT. SHANNON J. BEERS, 407 AEG, MUWAFFAQ SALT AB, JORDAN. Just prior to landing with a diminished fuel state at Muwaffaq Salti AB, Jordan, Capt. Beers experienced an anti-skid light after landing gear extension. Upon landing, Capt. Beers flawlessly executed the steps of the anti-skid malfunction checklist. Capt. Beers' actions and knowledge ensured safe recovery of an aircraft with diminished directional control. *(Awarded Jan. 2014)*

Unit Safety



20TH RECONNAISSANCE SQUADRON, CREECH AFB NV. The 20 RS designed and implemented the unit's first-ever digital RM program, enhancing the ability to identify and mitigate ground and flight safety risks. The program allows squadron leadership to quickly identify unit-wide trends and intervene to create a safer operation. They re-vamped its high risk activities program implementing a SQ/CC-led HRAs briefing process, modeled from checklists in the Creech HRAs program guide. *(Awarded Nov. 2013)*

20TH EXPLOSIVE ORDNANCE DISPOSAL FLIGHT, SHAW AFB SC. Alerting other flight personnel, the member began immediate firefighting procedures. Another entered the rear compartment with the appropriate dry chemical fire extinguisher and began fighting the fire through the thick smoke. The equipment bay was opened to ventilate the area, the fire department was notified, and equipment removed from the area. Once the initial fire was contained and personnel were out of the rear cab, the flight's NCOIC, directed personnel to drive the smoldering vehicle out of the structure to prevent further damage or fire sprinkler system activation. *(Awarded Dec. 2013)*

Crew Chief Safety



STAFF SGT. LUISEL N. ROLON, 380 EAMXS, AL DHAFRA AB, UAE. While recovering an aircraft from a combat sortie, Sgt. Rolon discovered a nut holding the wheel and tire together on the right main landing gear's tire had sheared. This discovery prevented a potentially catastrophic tire loss during takeoff or landing roll. His attention to detail and actions directly prevented the potential mishap of a \$330M aircraft. *(Awarded Nov. 2013)*

AIRMAN 1ST CLASS MARQUISE A. BARFIELD, 849 AMXS, HOLLOMAN AFB NM. A1C Barfield was performing launch procedures on an MQ-1B aircraft when he noticed sparks arcing from the ground power unit to the aircraft power panel and performed emergency actions. His quick reaction preserved a \$4.2M combat training MQ-1B and allowed the affected aircraft to successfully fly a Code-1 sortie the following day. *(Awarded Dec. 2013)*

SENIOR AIRMAN RANDEL J. KEPHART, 823 MXS, NELLIS AFB NV. While SrA Kephart recovered a HH-60G, he noticed smoke coming from the right-hand main landing gear and immediately directed the aircraft to stop. After analyzing the volatile situation, he determined the cause of the "hot brakes" condition to be a stuck parking brake. He quickly addressed the situation to allow aircraft recovery then thoroughly checked the brake system and components to allow the aircraft to quickly return to operations. *(Awarded Jan. 2014)*

Weapons Safety



TECH. SGT. MILTON R. AVANT, 355 EMS, DAVIS-MONTHAN AFB AZ. Sgt. Avant displayed extraordinary weapons safety awareness and superior leadership abilities as he responded to an Inflight Emergency for a catastrophic GAU-8/A 30 millimeter gun system failure. Sergeant Avant's actions to remove the gun firing cam, safing cam and barrels were successful in freeing two chambered 30 millimeter projectiles. *(Awarded Nov. 2013)*

STAFF SGT. WILLIAM M. BEARD, 455 EAMXS, BAGRAM AF, AFGHANISTAN. Sgt. Beard skillfully and professionally performed his duties as a Squadron Load Crew Chief conducting 28 in-depth aircraft post-load inspections on A-10C aircraft and identifying/correcting nine loading errors, averting multiple potential munitions in-flight mishaps. *(Awarded Dec. 2013)*

STAFF SGT. JOHN PAUL WHITE, 7 AMU, HOLLOMAN AFB NM. While performing a weapons supervisory post load inspection on AF05-100, Sgt. White noticed an excessively loose captive CATM-9M tail fin. Upon inspection he identified one of four bolts missing used to attach the tail fin assembly to the missile body. After the search to recover the bolt was unsuccessful, an immediate one-time inspection of all assigned CATM-9M missiles was conducted and determined that all remaining missiles were flight worthy. *(Awarded Jan. 2014)*

Ground Safety



MASTER SGT. PAUL BULLEMAN AND TECH. SGT. MARCO TREJO, 432 AMXS, CREECH AFB NV. Sgts. Bulleman and Trejo created a probationary period which requires no less than three meetings with the Squadron Commander and provides a comprehensive evaluation of a new rider's abilities, ensuring all motorcycle safety requirements and driving abilities were met prior to being allowed to ride alone. They ensured accuracy of the database and day-to-day tracking, and also eliminated 63 percent of known discrepancies within the squadron's 48 motorcycle riders. *(Awarded Nov. 2013)*

AIRMAN 1ST CLASS DILLON H. CLEMENT, 4 CES, SEYMOUR JOHNSON AFB NC. Amn Clement reported to the Asst. Chief of Fire Prevention that he smelled smoke while exiting his shower. He discovered that the top of his bathroom door appeared to be charred. His initiative and sense of urgency with bringing this issue forward led to a Fire Safety Deficiency One being instituted. His efforts prevented an imminent structure fire, potentially saving lives and costly damage to dormitories at Seymour Johnson AFB and throughout the Air Force. *(Awarded Dec. 2013)*

STAFF SGT. ERIC L. CHAMBERLAIN, 965 AACs, TINKER AFB OK. Sgt. Chamberlain fully revamped the 965th Airborne Air Control Squadron Job Safety Training Outline (JSTO); providing tailored safety training for 236 personnel. The training provides essential hazard abatement tools, emergency evacuation routes, and reviews risk management principles. His efforts were recognized by the 552 ACW/SE as "best seen at Tinker" and his JSTO was distributed to 16 units to serve as a model. *(Awarded Jan. 2014)*

Flight Line Safety



STAFF SGT. BENJAMIN R. MCINTOSH, 455 EAMXS, BAGRAM AF, AFGHANISTAN. Sgt. McIntosh was dispatched to an A-10C to troubleshoot the aircraft for a #1 engine no-start on a critical combat sortie. After discovering an oil leak coming from the engine turbine starter, he replaced the unit and ensured proper oil servicing two hours ahead of the allotted time for these actions. His attention to detail returned the aircraft to fully mission capable status and prevented further engine damage and loss of maintenance hours. *(Awarded Nov. 2013)*

MASTER SGT. WILLIAM L. HARPER, 43 AMU, TYNDALL AFB FL. Sgt. Harper noticed an aircraft rolling forward towards hardened sun shades and other aircraft due to a loss of hydraulic pressure caused by APU failure. He quickly attempted to chock the left main landing gear tire of the moving aircraft and after a second attempt, the aircraft finally stopped. Sgt. Harper's courageous act prevented a potentially catastrophic mishap. *(Awarded Dec. 2013)*

SENIOR AIRMAN TREVIS D. HIGHTOWER, 455 EAMXS, BAGRAM AF, AFGHANISTAN. SrA Hightower was dispatched to an aircraft to troubleshoot for reduced flight-control authority during Precision Attitude Control engagement and abnormal bullet spread during gunfire. SrA Hightower quickly identified a faulty Integrated Flight and Fire Control Computer causing the issues. He rapidly removed and replaced the faulty computer and performed all comprehensive operational function checks three hours ahead of the allotted time, returning the aircraft to combat operations. *(Awarded Jan. 2014)*

QUARTERLY AWARDS

Flight Safety

CAPT. DALE A. STARK, 354 FS, DAVIS-MONTHAN AFB AZ. During a high ops tempo reconstitution period, Capt. Stark expertly prepared and conducted three critical safety briefs that emphasized high potential risks to aircrew and provided proven techniques to mitigate. He brilliantly tailored the revitalized program to systematically track all A-10C emergency procedures and prepare pertinent monthly flight safety topic discussions. Capt. Stark accomplished 16 flight safety inspections, one of which resulted in the discovery that refueling trucks in the live load area were working in a location that did not allow for adequate wingtip clearance for taxiing aircraft. His valuable inspection led to the relocation and painting of new taxi lines, thereby greatly reducing the risk of a taxi mishap. Capt. Stark's outstanding efforts were also evident when the safety program received zero discrepancies during a recent wing-level inspection.

Ground Safety

STAFF SGT. BRITTNI L. KULP, 355 FSS, DAVIS-MONTHAN AFB AZ. During the last three months, Sgt. Kulp has promptly coordinated with the Fighter Wing Safety office on 24 mishaps without delay. She has done this by briefings/emails/and one-on-one training throughout the squadron. She is motivated and diligent in fixing open write-ups — closed over 16 discrepancies this quarter. Sgt. Kulp has also implemented Risk Management Training for the whole squadron. Sgt. Kulp spearheaded the coordination of a multi organization confined spaces inspection team ensuring proper application and safety of all. She is dedicated to making sure the FSS is a safe working environment for her team and customers by completing over 17 spot inspections on 13 facilities and correcting hazards on the spot. Sgt. Kulp is dedicated to making the squadron a safer place every day.

Weapons Safety

MASTER SGT. RASHUN D. STINSON, 57 WG, NELLIS AFB NV. Sgt. Stinson manages the Air Force's most dynamic weapons safety program and provides risk management for 7.1 million pounds of net explosive weight valued at \$112M. Despite directing 75 percent of the Air Force's live ordnance training, Sgt. Stinson's superior and proactive performance has resulted in zero Class A or B mishaps. Sgt. Stinson led the investigation efforts and secured evidence to mitigate the electro-static hazard and averted a CAF-wide \$7.4M 20mm round restriction. He manages 183 explosive safety facilities which enable arsenal storage worth \$175M and ensures joint and combined weapons training. Lastly, he was the lead investigator for a fuel probe risk in which his analysis saved an \$8M project by eliminating 52 civilian exposures and ensuring that 30 vital aircraft parking spaces were usable.

Note: Due to space constraints the above award write-ups were shortened and only represent a portion of the winning narrative originally submitted.

Congratulations to the 57 WG Flight Safety office for achieving an ACC Safety “Best Practice”

57 WG Flight Safety has instituted quarterly Maintenance Safety Meetings involving maintenance leadership and supervision which has reinforced safety process principles and relationships within maintenance functions as well as with the safety office. This innovative practice incorporating the maintenance perspective has tremendously improved mishap investigations and information flow, immediately shattering misconceptions and coordination problems. Great job 57 WG Flight Safety!

Mishap Statistics Scoreboard

FY14 Flight

As of January 31, 2014

	Fatal	Aircraft Destroyed	Class A Aircraft Damage
1 AF			
9 AF			
12 AF		MO 11 ** MO 11 ** X2	
USAFWC			
ANG	1 ****		
(ACC-gained)			
AFRC			
(ACC-gained)			

FY14 Ground

As of January 31, 2014

	Fatal	Class A	Class B
9 AF	1	2	1
12 AF	1	3	0
USAFWC		0	0

FY14 Weapons

As of January 31, 2014

	Class A	Class B
9 AF	0	0
12 AF	0	0
AWFC	0	0

Legend

Class A - Permanent Total Disability; Property Damage \$2,000,000 or more
Class B - Permanent Partial Disability; Property Damage between \$500,000 and \$2,000,000
Class C - Lost Workday; Property Damage between \$50,000 and \$500,000
(Class Description Effective October 1, 2009)

* Fatality ** Non-rate Producing *** Performing SOUTHCOM Mission

1 = Fatal 1 = Fatal due to misconduct

Flight Notes

During the first quarter of the FY, ACC experienced four Class A mishaps. These were comprised of a MQ-1 experiencing a lost link, a MQ-1 experiencing an engine failure, a MQ-9 experiencing an equipment failure, and a fatality during a SOUTHCOM mission. As we enter the next quarter with ample flying hours and training opportunities, we need to remain focused on risk management while we work towards being combat mission ready. Properly utilizing risk management and knowing when to call “knock-it-off” can be the difference between overall mission success and mission degradation. On the maintenance side, the new year comes with new challenges for all leadership levels. Technical data violations often lead to undesired results and led the last FY as the number one issue. Leadership focus on proper training and “top down” involvement will assist in addressing this issue. FY14 looks to be a great year for flying.

Ground Notes

During a recent five-year review of AF-wide fatalities we noticed a surprising trend. Tire condition was found causal in several mishaps. Some had a tread depth below the required 2/32” depth, some were from bald tires, and some were from faulty tires that came apart. There were also a couple that had other mechanical failures, such as an axle broke or unsafe modifications were made. Please ensure your vehicles/tires are in safe working condition and modifications are safe.

Weapons Notes

ACC experienced only one reportable mishap in the first quarter; “knock, knock.” A TGM-65 Radom was found cracked while hanging on an aircraft. Equipment failure was causal for that mishap. This is an impressive statistic given neither human factor nor technical violation was causal. Continue implementing mishap prevention techniques and following guidance to help mitigate risk. Thanks for all that you do in the weapons safety community ... keeping us safe and striving for excellence!

Symbols for Mishap Aircraft





**In This
Issue**

Where's Our
Boat? **PAGE 4**

Fatigue and Driving
Do Not Mix **PAGE 8**

If It's Not You
It May Be ... **PAGE 12**

OVER the Edge MAGAZINE



Where's Our Boat?

PAGE 4



Summer is coming ...

ARE **YOU** READY?



4 | **WHERE'S OUR BOAT?**

*by Staff. Sgt. Alberto V. Da Silva
325th Fighter Wing Safety, Tyndall AFB, Fla.*

8 | **FATIGUE AND DRIVING DO NOT MIX**

*by Master Sgt. David Ingram
HQ ACC/SEW, Joint Base Langley-Eustis, Va.*

12 | **IF IT'S NOT YOU**

*by Senior Airman Kelly Galloway
439 AW/PA, Westover ARB, Mass.*

Where's Our Boat?

BY STAFF SGT. ALBERTO V. DA SILVA

On a beautiful Sunday not too long ago in Panama City, Fla., a good day turned into a bad day really quickly. The temperature was just right. The winds were calm and the tide was super low. Perfect to go walk around finding shells. We decided to hit the beach.

We made sandwiches, packed water, extra towels, dog toys, beach toys, kite boarding gear, drinks, life jackets and a few other odds and ends. The day went wonderfully.

It was starting to get late and the wind was getting a little cooler and stronger. We piled our puppies and gear into the boat. Nothing was left behind. I decided to try something different. I was going to stand on the bow and throw the anchor out and pull the boat by it until we got to deep enough water for me to crank the engine. The idea worked perfectly.

Pam, my wife, asked if we could make a small stop. We were having a great day, I said why not. We came around the tip and I beached the boat in one of our other usual spots. We got our dogs, our little girl, and ourselves out of the boat and dropped the anchor.

We went for a short walk. On the way back, I noticed that the boat looked much further from where we had originally left it. Panic set in. The boat drifted a half-mile into the middle of the bay. The anchor was still there on the sand where I left it. We didn't take anything out of the boat when we jumped off for this short walk. We were stranded.

I made a few quick decisions that would almost cost me my life. I knew I was a good swimmer. I calculated how good I am in the water, but not what affect the February water had. I dove in the water and off I went.

My hands were numb and I could not move my fingers. Then, I looked at the boat and it was still the same distance from when I started. I knew I was in trouble and I knew this was the beginning of a fight that I could not lose.

I weighed my options and measured my chances. Even though the boat was the closest thing to me, there was no way I was going to reach it. The opposite shore was another mile and even if I floated I would be frozen before I got there. Going back was my only option.

I turned back, saw the little figures of my family members on shore, aimed in that direction and started swimming. Realizing I was going against the wind and the incoming tide, my best option was to swim at a 45-degree angle toward shore.

I no longer had feeling on either of my arms up past the elbow. I wasn't able to take a full breath no matter how hard I tried. I had made progress. If I could swim another 120 yards, I'll reach the sandbar and be able to stand. This was great news, I can make it, I thought.

I went under. I thought about my wife, I thought about my daughter, I thought about my family, my dogs, my school, my teammates. The pain was unbelievable. A funny thought came to my head, out of all the things that have happened to me, am I really going to die like this? I've survived so many things and this is how I'm going to die? Then I realized, if I'm down here still thinking, I can still find a way to fight and not give up.

I pushed with everything I could imagine, I want to see my family one last time if this is how I was going to go. I inhaled in tiny bits and one word at a time, I yelled, "Naomi, I

love you, Pam, I love you," I looked at our puppies and inside I asked to be forgiven. When I couldn't move, I just said "goodbye" and went under again.

This time the water didn't burn so much. It just tasted weird. I felt my entire body cramp, and it began to shake, it wanted air, but just took in water. I knew these were my last few moments. I think I felt something touch me and pull.

I came to a few minutes later while I was on my hands and knees trying to get out the water. Finally panic set in. I had said my goodbyes, I had made peace with myself, but she made the choice not to lose. While our dogs watched our toddler, my wife faced the frigid waters and pulled me out.

With her help, I managed to get my body on dry sand. I looked up and noticed the sky was beginning to turn dark blue and everything became black. Pam tells me I was out for not more than two minutes. To me it felt like an eternity. I opened my eyes, I was able to think more clearly at this point and I began to try to move.

I was able to stand on my own two feet. It felt like I weighed two tons. I could barely

lift my toes off the ground, but I moved. Grunting, drooling, watching everything around me spin, my heart beating easily over 200 beats per minute, I was able to walk. My breathing was still shallow, and I couldn't form words.

Pam asked several times if there was something that she could do, I think I waved her back. My body laid there for the next 15 minutes until I began to feel my heart rate go down.

We walked over five miles in very soft sand, carrying our daughter. No food, no water, no phones, no car keys, we finally got to the beach boardwalk. Pam, the baby and the dogs stayed behind while I went to find a friend.

Once we returned home and ate, we began the journey to retrieve the boat. Fortunately, we had turned on the "find my phone" feature on our phones and we were able to pinpoint the exact location of our boat. We contacted another friend to help us and within minutes he was at our home picking me up to go retrieve the boat.

It ended up being an extremely long and exhausting day.

Here are the few lessons our family learned that day:

1. Never chase the boat.
2. If you leave the boat, take everything with you.
3. Take life jackets with you when you get off the boat. (Keep the spares in the boat.)
4. Always make sure the anchor is tied properly to the boat.
5. Two anchors are better than one.
6. Always bring a few pieces of warm clothing to the beach. (You never know when something may cause you to camp for the night.)
7. Never, ever play with boating equipment.

The next day, I realized what had caused the entire ordeal. When we left our original location, I had used our anchor to pull the boat to deep water. I had untied the anchor from the cleat, something I only do once the boat is on its trailer. When I dropped our anchor in the new location, it wasn't tied to anything. 🌟

Fatigue & Driving DO NOT MIX

*Life; what is this thing called life? What is your perspective of life? Do you cherish your life? Do you take life for granted? Do you enjoy the life you live? On November 3, 2012 at approximately 3 a.m. on a cool Saturday morning in Edison GA, my life as I knew it changed when a vehicle I was traveling in crashed, leaving me with severe injuries. **I am alive today because I was wearing a seatbelt.***

BY MASTER SGT. DAVID INGRAM

I took two weeks of leave starting at the end of October 2012 with what I imagined to be a wonderful time at home visiting family in southern Georgia. After a few days at home, things were slow and uneventful—that's typical for my small hometown. At the end of the week, I attended a football game at the school I graduated from some years ago. While at the event, I laughed, talked, and mingled amongst friends; many I had not seen in years. The day quickly turned into night and the weather began to cool. By this time, the football game was almost over and people were packing up to leave the festivities. At the end of the game, my brothers and I decided to travel to a neighboring town to grab a late night snack before going home. My oldest brother drove us to a restaurant in the nearby town which is about 40 miles away. We arrived at the restaurant, took our seats, ate, and left for the return trip home. By this time it was around 2 a.m., Saturday morning. On the way home we laughed and told a few jokes. I was in the passenger seat up front, and started to get a little sleepy, so I asked my brother Sam, who was driving, if he was ok to finish the trip home; he said that he was good to go. I was under the impression that my other brother Randy (sitting on the back seat directly behind Sam) was going to stay up with him until we got home, since he works at night and was wide awake.

Shortly thereafter, I fell asleep. The next thing I remembered was hearing a sudden rumbling noise which sounded like our vehicle was running over the rumbling strips on side of the road. All of a sudden it got quiet and then there was a loud "BANG" followed by a smaller one. I was dazed and finally realized that we had crashed. It felt as though I was dreaming because the first thing that I saw was a church about 20 yards from where we finally stopped. After I gathered myself, I looked around and noticed my brother slumped over the steering wheel not moving. I started calling his name without any reply; suddenly he jumped as though he was temporarily dazed. At first glance, I couldn't tell if he



had any injuries, but I knew I was injured. My whole body felt numb and my stomach began to swell instantly. I realized it was really bad because I could barely move. Meanwhile, my brother jumped out of the truck, came to my aid, and realized just how bad I was injured. He dialed 911, helped me out of the vehicle and rested me on my back next to the truck. I started to get really cold and became frightened; I was losing blood steadily. The ambulance arrived about 45 minutes later. They put me on the stretcher and into the back of the ambulance and drove away with lights and siren blasting. I lost consciousness shortly into the trip. When I awoke, I was in the recovery room awaiting transport to my room where I would spend the next 12 days. The next day I asked what happened and was briefed. My brother fell asleep while

driving; we left the road, hit an embankment sending us airborne over a gully, then nose-diving into the upside of a country road. As a result of the accident, I sustained multiple injuries. My right thumb was broken; I had a large laceration on the side of my face continuing underneath my chin. It took 35 stitches to close the gash on my face. The laceration was the result of the seatbelt doing its job. Some of my ribs were broken; my right ankle was fractured, some of my teeth were shattered resulting in a large gash on my tongue. I lost almost two liters of blood and, had 13 inches of my small intestine removed. Luckily, my brothers sustained minor injuries and were treated and released the same day.

Almost a year later, I'm still receiving medical treatment and I know that my life will not be as it once was. Oftentimes, I encounter physical and mental frustrations accepting the fact that my life has changed; but I am grateful to still be here on this earth.

We were wearing our seatbelts! However, even though I sustained multiple injuries, our lives were spared because we chose to wear them. Alcohol was not a factor in this accident, but fatigue was. Each time I think about that night, I regret falling asleep and assuming that my other brother would stay awake and keep the driver company. I guess we weren't very good wingmen! While driving during the night, it is mandatory for at least one person to stay awake to keep whoever is driving company. This accident showed that routine actions and assumptions can often



generate complacency. Statistics show that most accidents (69 percent) occur within 10 miles of home (we were less than three miles from home).

**Bottom Line:
Wear your
seatbelts ... they
do save lives and
I'm living proof!**

If It's Not You

It may be the person next to you

BY SENIOR AIRMAN KELLY GALLOWAY

I turned to see a fellow Airman in training; standing about 5 feet 8 inches tall, dark hair and eyes. Over the next four months, I heard this fellow classmate repeat the same line more than a couple dozen times.

It wasn't just me he had an eye for; it was a handful of my new girlfriends as well. We laughed it off. All of us had just completed basic training and were beginning another chapter in our brand-new military careers at technical school. Why make enemies at the start?

About a month in, I grew tired of the cheesy pick-up lines and over-used sexual innuendos. I asked one of our ropes (student leader) to step in to have a chat with the guy regarding how uncomfortable he made me.

Unfortunately, that chat didn't have much of an effect on the Airman and as "luck" would have it, I sat next to him during class.

Lucky me ... right?

I was pretty good at letting his suggestive comments flow in one ear and out the other, careful not to show it bothered me (as that only added fuel to his fire). Up to this point, his words were the only offensive thing he had been doing. But then I dropped my pencil. As I stooped over to pick it up I heard a loud voice boom throughout the classroom.

"Are you serious, Airman?"

Startled, I nearly smacked my head on the table trying to sit back up. With our entire class now looking back toward us, our two class leaders, Marines, shrugged them away and stated "We'll talk about this at break—carry on."

Unbeknownst to me, this guy had just executed one of the foulest and sexually suggestive hand gestures behind my head. The class leaders luckily sat behind us and saw what he had just done.

That was the final straw. The class leaders already knew how annoyed I was by his behavior and asked if I wanted to take this latest development "up the chain." I had no intention of getting anyone in trouble since we were all brand-new to the military. I'd hoped that the class leaders had scared him enough by this

point and decided against it—asking only to move seats to get away from him.

With my new location in the classroom, I felt a bit more at ease. Although the Airman now had one of his male friends start to jeer me because I had gotten him in trouble. I felt beaten and angry. I had no control over the situation, it wasn't "my" fault he did what he did.

He was lucky I didn't take it up the chain of command.



Photo Illustration by: Senior Airman Marc I. Lane



About a week after the hand gesture incident, I'd had it with the remarks from him and his friend. That's when I asked one of our former ropes in our dormitory to have a talk with these two guys. This former rope commanded the respect of all the guys in the Airman dormitory; certainly he would be able to have an impact on this guy. Shortly after the discussion this time, the jokes and rude remarks stopped all together. The Airman and his friend now completely avoided me—Victory at last!

Three months later, two weeks before our class graduation date, a female instructor came up to me as I was on my way back from a class assignment.

"Airman Galloway, follow me, please," she said.

I proceeded down the hallway and into a small room with a handful of computers and two girls from my class already in place.

Confusion and a spark of panic overcame me when the door was shut behind me and I realized something serious was going on. One of the female Airmen had been crying and her eyes were still puffy and red.

"Galloway, as I understand, you had a harassment issue with a particular Airman?" my instructor asked.

I acknowledged her question and explained my experience with the group and asked why this was just coming to light as the incident happened nearly three months prior.

Her response shook me to the core as she explained that the two female Airmen, fellow classmates, had just had the same type of harassment, only it had gone above what this man had done to me.

The Airman allegedly grabbed one of the girls and cornered her in an area where we kept our equipment. He put his hand over her mouth and pushed her back against the lockers—pressing his body against hers and proceeded to kiss his hand in a suggestive way.

This was why I was being called into the room, the other girl was witness to what happened and they both wanted to open an investigation after speaking with the sexual assault response coordinator (SARC) on base.

They knew I had been in a situation and wanted to know if I also wanted to open an investigation.

I realized that what was thought to be simple but annoying joking was turning into something much more serious.

How much more would his behavior deteriorate? What if I had reported this incident when it happened to me? Would this still have happened to this girl?

All three of us had to give her our written statements separately and without prejudice.

After reviewing our statements, she concluded that there was a definite issue and asked us individually if we wanted to proceed with a restricted or unrestricted report.

We all wanted the unrestricted report.

We were sent back to the dormitory after meeting with the SARC to speak with our military training leaders. Upon arrival, the captain was already waiting for us. As we entered her office, at attention and visibly shaken, she asked us to sit down. Up until this point, we had not had any personal interaction with this busy officer and had grown to fear having to report to her.

"Ladies, first of all I want you to know that you are not alone," she said. "Secondly, I want to assure you that this Airman will be dealt with and I will do everything to ensure your safety and confidentiality of this situation, but you need to ensure the confidentiality on your end as well."

"Yes, Ma'am," we simultaneously squeaked out.

We had already signed confidentiality agreements and were ordered not to talk about the situation to any of our classmates.

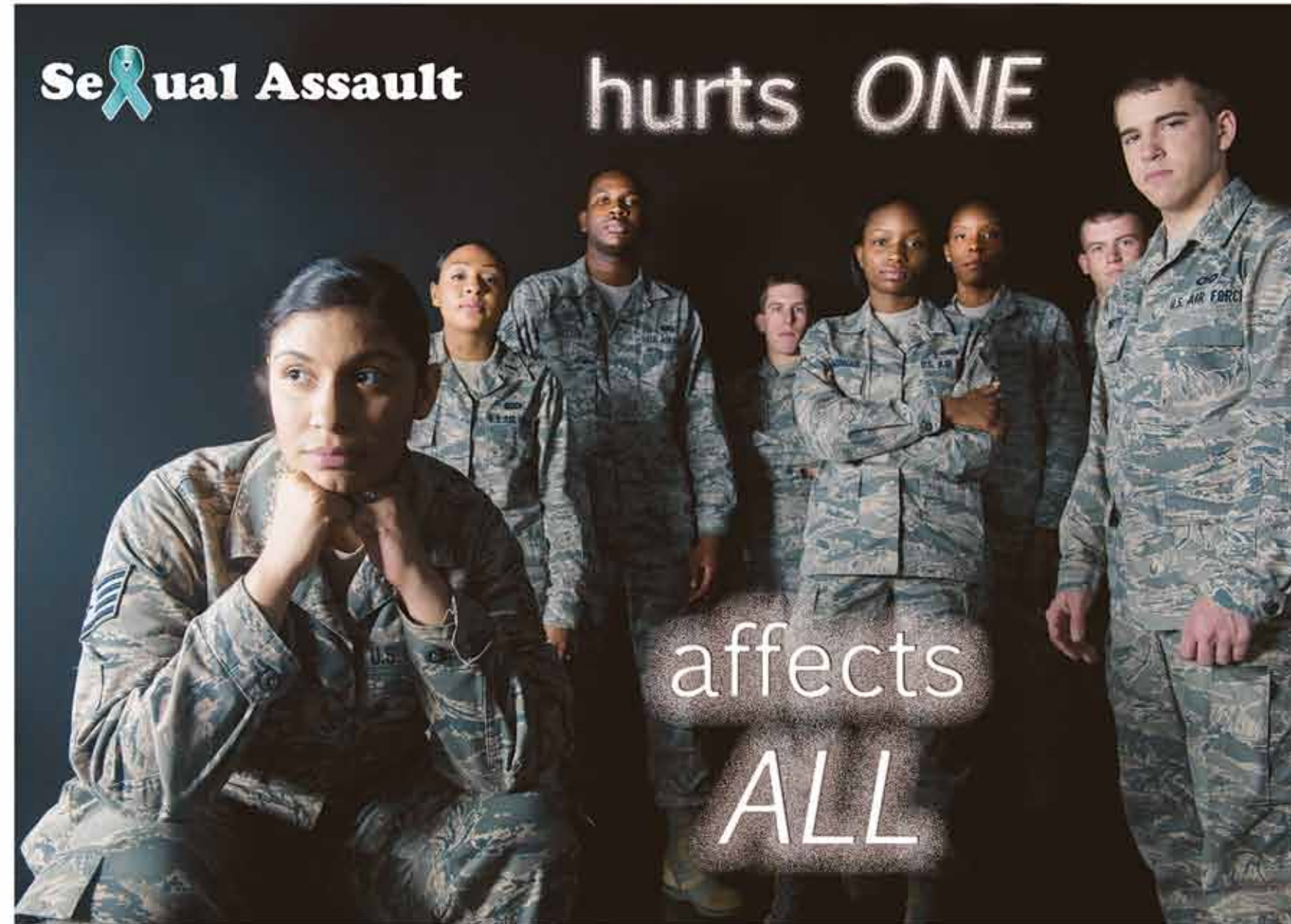
After an hour of conversing with the captain, she released us to go back to our rooms to deal with what had just occurred in our own manner. What had started as a normal day had taken such a dramatic turn of events. Our minds were warped. We were mentally exhausted.

A team of OSI agents came to our dormitory as well as military police, who went through the Airman's room seeking incriminating evidence. They pulled him from class and brought him back to the dorms so that he could pack his belongings.

He was being isolated from the rest of the dorm, moving onto the first floor near our MTL's offices.

We were only two weeks from graduating. Because of this incident, the Airman jeopardized his marriage, his security clearance—and his military career.

Beginning in basic training, all of the advice from my military training instructor had prepared me for something like this, though I never thought I would be involved in a "SARC" case. It was something we had joked and laughed about in training. Yet my MTI knew better. Before we left his watchful eye he warned us that an alarming number of technical school SARC cases do happen and will happen and that we should prepare ourselves. His words still ring in my ear like reveille in the morning. "If it's not you, it may be the person next to you." ■



The thoughts in my mind raced. I agreed to speak to the SARC.

The concept of an entire office committed to sexual assault boggled me. I had no idea what was in store as the three of us walked into the SARC office to again explain what happened. To my relief, the officer was approachable and sincere; she made every effort to ease our minds and explained what was going to happen.

A restricted report requires the member to be in status and can only report the incident to medical personnel, SARC or a victim advocate, but an unrestricted report means the member can report the incident to investigative agencies such as the Air Force Office of Special Investigation or security forces, as well as to members in their chain of command such as the first sergeant, supervisor, or commander.