

THE COMBAT EDGE

AUGUST 1999





THE COMBAT EDGE

Air Combat Command
Safety Magazine

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OUT OF GAS IN AN AARDVARK!

I remember having the cold chills on taxi out and something kept telling me that I would have been a lot better off sleeping, than launching on a 3,000 mile flight.

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ACC SP 127-1 VOLUME 3 ISSUE 3

ACCent on Safety

Greetings again. My congratulations to each and every member of ACC who made this recent 4th of July weekend a relatively safe and enjoyable one. The command suffered no Class A ground, weapons, or flight mishaps over this high threat holiday—a tribute to you all!! It is especially gratifying to know that we were all able to concentrate on celebrating the independence of our nation as well as enjoy being with our friends and family to have fun in a mishap-free environment. It sure makes my holidays a lot more enjoyable when I don't have to read about or work on handling the aftermath of a major mishap involving injury or loss of life—again, thanks for the help and support!

In the way of a Stakeholder's report, the command continues to do well in Weapons and Ground Safety and is basically holding its own in the Flight Safety area. Our trends in off-duty mishaps/fatalities seem to remain steady—failure to use safety restraints (seat belts and harnesses) and excessive speed causing loss of control. Two recent mishaps were the result of failing to yield or stop. In both cases, the vehicles were hit by other vehicles—in one instance, an 18-wheel cement truck. I guarantee you won't win that contest and seat belts in this

case did not save the day. The lesson relearned is obvious—traffic signs and posted limits are there for a good reason—to help save lives. Obey them and you'll not only save a citation and fine, but will probably be around to celebrate many future birthdays and holidays.

In the flight arena, we continue to be challenged with human factors mishaps. The aircrew, supervision, ATC, etc., contributed to or caused six of our nine active duty Class A flight mishaps thus far this fiscal year. Although we continue to work this hard and have made some modest headway, I am still deeply concerned that distraction, loss of situational awareness, and other factors continue to plague the command. We must continue to work toward a cultural approach to safety that makes each and every one of us question the need to take or accept unnecessary risk in our flight operations. Too much in terms of lives, resources, and combat capability are at stake—fly smart and safe!!

Lastly, I hope you are all gearing up for next month's command-wide **SAFETY DAY**. We've come a long way over the past ten years but cannot rest until we reach our stretch goal of **ZERO MISHAPS. WE CAN DO IT!!**

*Colonel Bob Jones
Chief of Safety*



ABOUT THE COVER

The photograph for this month's cover was taken by SSgt Blake R. Borsic, 93 CS/SCCV

"GERRYMAND

The Sign of the Times!

*Lt Col James D. Teigen
HQ ACC/SEF
Langley AFB VA*

(DEALING WITH THE REALITIES OF THE BRAC COMMISSION)

Webster defines **Gerrymandering** as: "1: to divide (a territorial unit) into election districts to give one political party an electoral majority in a large number of districts while concentrating the voting strength of the opposition in as few districts as possible 2: to divide (an area) into political units to give special advantages to one group."

Each base looks at its surrounding area and physically divides the country up into areas of responsibility for mishap investigations and disaster control/response force actions. In a sense, we gerrymander the country into areas of responsibilities. In case you're wondering, this is per the guidance in AFR 127-4, Para 1-2,d. and the sub paragraphs. You knew that; you're just wondering where this is going.

Now that the Base Realignment and Closure (BRAC) commission is a reality, we have another problem cropping up. What happens if the base that adjoins your area is scheduled for closure? Who is responsible for mishap investigations and disaster control/response force actions? When

will there be a transfer of the responsibilities?

All of these are good questions. Recently we had a base ask just those types of questions, and I'd like to take this opportunity to discuss the answers given.

The first question was since the base was slated for closure in FY 9X, what was their end responsibility time? They were asking could they arbitrarily "draw a line in the sand" and say that after that date they could no longer perform their major mishap response or investigation responsibilities. The Numbered Air Force answered this one with a good answer, "That is dependent on the particular unit and is dependent on the time when it is no longer capable of performing the task."

The second question was when might the closing unit dissolve their mishap board roster? The answer was the same: when the unit's capability to maintain a mishap board no longer exists. If the qualified individual is on station to perform those duties, then the roster and duties should be maintained. While we're at it, the answer should not delay normal rotation out of the unit of those

individuals identified as members of the unit's mishap response force.

The third question was who assumes the unit's mishap response duties when it does close? The answer to this involves all the other bases. As the unit's capability decreases, a close dialog with neighboring bases must take place to advise of end responsibility times. The dialog should be by message and the Numbered Air Forces (NAFs) and MAJCOMs should be informed of the end responsibility dates, in order to assist in the mishap investigation processes. These adjoining bases will be responsible for new and expanding areas of responsibilities.

Quite possibly an example could best demonstrate what should happen, by illustrating what didn't happen. Hopefully through this example we can learn how not to assist in the mishap investigation, mishap response process. We in ACC experienced a mishap at a non-USAF base some time ago. Initial response was provided by the sister service. After the board had formed and was in need of continuing assistance, a call for help went

DERING"

out to all. To the surprise of many, some of the answers were: "We've looked at our maps and that's pretty far away." Other answers went down hill from there. I got to hear stories about how much money it would cost, how broke the unit was, and more.

We found out that the "closed" ACC base near the mishap site had just enough folks to assist the board. It pointed out the shortcomings of our handling of base closures. The first thing is when is the base really "closed" and can no longer respond. In this instance, the ten folks who showed up were from all walks of life, and nearly the last folks on the base but their "can do" attitude saved the mishap board lots of extra time.

The second thing is we can all do a better job of talking to each other about the unit's capabilities to respond to a mishap. By keeping the nearby bases in the loop (let's not forget the NAFs and MAJCOMs), mishap responsibilities are not unknowingly dropped.

The third thing we need to learn is that in this era of declining budgets, mishaps can sometimes occur near the end of the money, before the calendar runs out. To this end, I can give some things I've learned in the years of safety and multiple mishaps I've helped out with. No unit can put in a

budget request for a pot of money for mishap investigations. If the MAJCOM doesn't red line that, the Air Staff will. Individual units can recoup their expenditures by going through their respective funding channels, through the NAF/Direct Reporting Unit to the MAJCOM Comptroller up to the Air Staff. The key "buzz word" is "unfunded requirement(s)." Where the monies come from, how fast, and how the system works is past my simple example, and beyond my need to know. That's what the money experts are for — use them.

Aviators will be able to relate to the following story. It is one of the unwritten rules of aviation and illustrates the need to help a fellow aviator after a mishap. The mishap occurred years ago; one night on a low-level route, an aircraft went down. Emergency Locator Beacons were sounding and there was another aircraft scheduled for the low-level route, just 15 minutes behind, loaded with fuel. As the second aircraft passed the mishap site, there was discussion among the crew as to how to help the mishap crew. The aircraft commander elected to proceed with the planned mission and not to take up Search and Rescue duties. There were training events to be accomplished, and the general area, although known to be very desolate, was

simply passed to the Federal Aviation Agency.

When I've told this story, other aviators cringe at the mention that a fellow "aviator" would depart the area and leave a downed aircrew without contact with the outside world.

So what's this got to do with supporting a mishap board or initial disaster response? Well, if I have to explain that to you, you've missed the point altogether, and there isn't enough paper in this magazine to dissuade you. If on the other hand you're a responsible aviator, or the many others on every base who support the initial mishap response force or the mishap board, it talks to you. We need to be aware of our responsibilities to respond and provide support for mishap investigations. It won't get any easier, because of base closures. It will take a constant effort on the part of those units and bases left to "re-gerrymander" their areas of responsibilities. It won't get any easier with tighter budgets. But the job must be done and done professionally. To do that, we need to open or continue a dialog as bases and units are identified for closure. We need to keep everyone informed of the unit's ability to respond to mishaps and support mishap boards. What we don't need is to ignore our responsibilities and "fly off into the night" leaving our fellow aircrew alone at the site of the mishap. ■

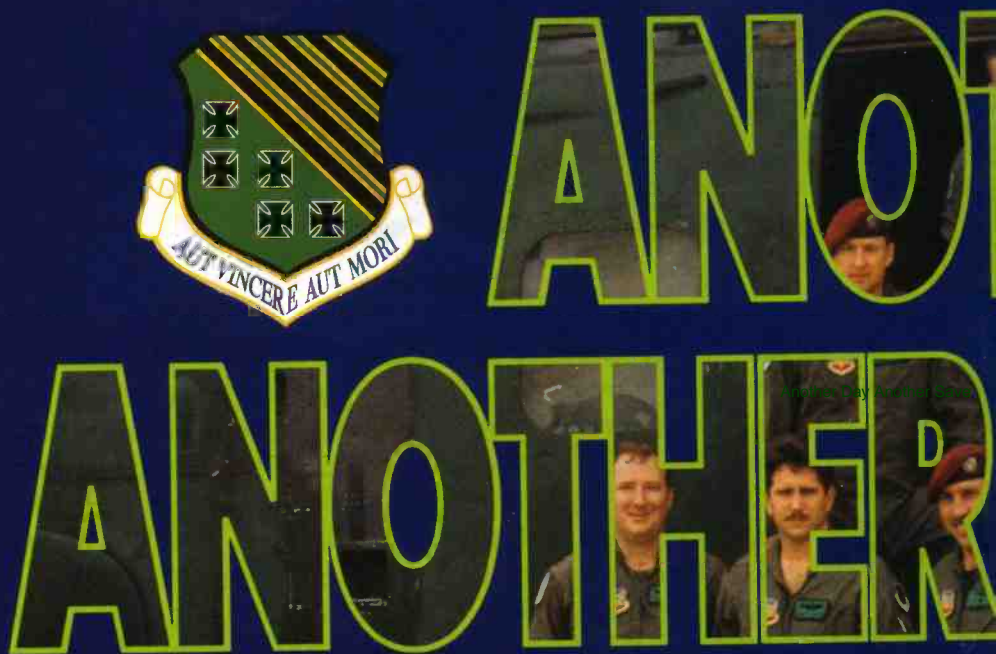
Capt John Coffindaffer
41 RQS
Patrick AFB FL



At 1135L on 26 January 1994, the 41st and 71st Rescue Squadrons were notified by the USCG Station Mayport of an injured seaman aboard the 67 foot fishing vessel *St. Elmo*, located approximately 200 nautical miles due east of Patrick AFB FL. The injured fisherman, a 39-year-old male, had fallen from the roof of the wheel house onto a metal rail fracturing several ribs, puncturing his lung, and seriously injuring his back. The *St. Elmo* had a ruptured fuel line and insufficient fuel to make it back to the Florida coast.

As the crew of Air Force Rescue 811 (HH-3E helicopter), we quickly organized and planned the mission and departed Patrick AFB for the *St. Elmo* at 1215L. At approximately 50 miles offshore, we rendezvoused with Air Force Rescue 853 (HC-130 Tanker) and air refueled to make sure that each aircraft's refueling equipment was operating properly prior to committing our helicopter outside its normal, unrefueled range. Ten miles southwest of the scene, we dumped 500 pounds of fuel in order to obtain the proper power safety margin for a high hover during the recovery phase. We also performed health checks on both engines to ensure engine performance was not compromised.

Once on scene, I made an approach over the water, next to the



vessel, and deployed TSgt Lowdermilk and SSgt Hehir using swimmer deployment procedures. I then made a second approach and deployed a stokes litter as requested by the pararescuemen.

After the pararescuemen prepared the patient for a hoist recovery, I conferred with the crew and decided that the best and safest means of recovery would be to have the vessel maintain a steady course 30 degrees off the wind line at approximately 5 knots. This would provide a stable platform for the helicopter, from which a hoist pickup could be performed over a clear section at the stern of the vessel. I held a steady 75 - 80 foot hover over the vessel for a stokes litter hoist extraction. While the stokes litter was being hoisted up, a large wave caught the vessel causing it to pitch up and to the right. As a result, the vessel was an additional 30 degrees off course from its original heading and moving away from the helicopter. The stokes litter, with the survivor in it, began to move with a pendulum motion to the left, proceeded to go in between the deck and a rail, and then entered the water — jamming the hoist cable against the vessel's rail. This situation, combined with the forward motion of the vessel, caused the stokes litter to be dragged under the water (like a water sea anchor), placing the survivor in close proximity to the vessel's propeller. SSgt Hehir jumped into the water, swam to the survivor, got the survivor to the surface where he could breathe again, and ensured the litter stayed clear of the boat's propeller. At the same time, MSgt Mayfield called for the hoist cable to be sheared. SrA Riddell immediately sheared the cable, which then entangled itself in the hoist drum rendering it useless.

MSgt Mayfield began improvising an extraction device from rappel ropes and caribeaners, utilizing his knowledge of litter evacuation procedures used in mountain rescue situations. He envisioned a rescue by clipping the ropes to the stokes litter and pulling in the survivor while the helicopter was in a low hover or landing in the water. After a successful

HER DAY SAVE



approach to a 1 foot hover over rough sea, the pararescuemen in the water were able to clip the ropes to the stokes litter which enabled MSgt Mayfield, SrA Riddell, and Capt Hurwitz to manually pull the survivor aboard the helicopter. Once on board, Capt Hurwitz began administering medical treatment to the patient. Next, we flew an approach back to the pararescuemen in the water so they could climb into the helicopter using a rope ladder.

On takeoff from the hover, I made smooth power adjustments because I knew the jet turbine engines had ingested a lot of salt spray that could severely degrade the engine's performance. At approximately 200 feet off the water and 50 knots forward airspeed, we experienced a compressor stall on one engine. The tell-tale loud bangs of this failure alerted us to the emergency situation. We immediately followed the procedures outlined in the current H-3 Dash One Technical Order and were able to stabilize the engine, avoiding a highly probable engine failure. We performed a health check on the engines and determined that we did not have normal power due to jet engine performance deterioration. By this time, the helicopter needed fuel in order to make it back to Patrick AFB.

With a power critical situation, I requested that the HC-130 fly underneath us at 1000 feet to set up air refueling operations. As the tanker came into view, I entered a shallow controlled descent, engaged the drogue of the HC-130, and obtained 1200 pounds of fuel — enough fuel for the helicopter to make it back on its own. The air refueling took place at 1000 feet and 105 knots airspeed over the ocean.

At approximately 90 miles east of Patrick AFB, Capt Kelly noticed the cyclic stick was beginning to drive forward. Capt Kelly passed the controls to me, and we decided that the helicopter's automatic flight control system (AFCS) was malfunctioning and should be turned off. The HH-3E is safe to fly when the AFCS is turned off, but flies unsteady. Meanwhile, Capt Hurwitz and the pararescuemen were providing life-

saving medical attention to the patient. After conferring with the crew, I elected to make a minimum power running landing to Runway 11 and landed without incident.

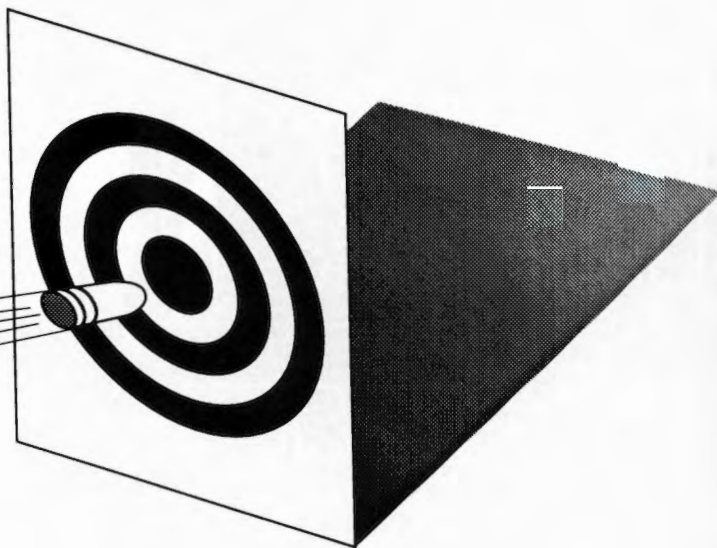
The helicopter ground taxied to base operations where an ambulance was waiting to take the patient to the hospital.

41 RQS/CC COMMENTS:

In an outstanding effort, the crew was able to cope with an emergency situation on the helicopter's hoist system, and then improvised an alternate method for the recovery of the survivor. They responded, in a cool and professional manner, to an engine compressor stall during the critical stage of take-off from a 40 foot water hoist. They also accomplished a successful, emergency helicopter single-engine air refueling in order to extend the helicopter's fuel range and prevent a potential ditching situation. Finally, they responded to an automatic flight control system malfunction that increased the pilot's workload during the critical stage of landing the helicopter with an injured patient on board. If not for the gallant efforts and teamwork of the helicopter and HC-130 aircrews, the patient would not have lived from the injuries sustained during his fall. In addition, Air Force Rescue 811 crew's superior airmanship, along with their expeditious and accurate assessment of multiple emergencies, resulted in the successful recovery of a valuable Air Force aircraft and the saving of all lives on board.

KEEP US

ON TARGET



The *Combat Edge* mission is mishap prevention through safety education, recognition, and marketing. We are dedicated to providing command personnel with thought stimulating flight, weapons, and ground safety information so we can all learn from the pages of a magazine rather than painful personal experience.

Quality, to us, is meeting the expectations of our customers in the products we provide them. In simplified quality terms, we supply a product (*The Combat Edge*) to you the customer (reader). We are totally focused on our product and our customers. We measure our outputs to determine how well we are satisfying our customers with our product. Customer satisfaction is not just a buzzword — it's a two-way street. It requires two parties, a customer, and a supplier, with separate but equally important responsibilities. To satisfy you, our customer, we must know what it is you need, want, and expect. You have to let us know your needs and desires so we can better serve you!

How can you do this? Complete a survey and forward it to us. We know you don't have much time to spare, but please squeeze a few minutes from your busy schedule to fill out the survey form. We've included two forms in each copy of the magazine and encourage local reproduction so everyone can let us know what they think.

The survey includes some questions about you.

We're not trying to invade your privacy; we just want to know more clearly who it is we're communicating with. With that information, we will be better able to tailor the magazine to your interests. Please, no names.

The rest of the form lets you sound off to us. Tell us what you honestly think about the way we're doing our job. Don't worry about hurting our feelings; just be as honest and accurate as you can. When you're finished, fold and **TAPE** (no staples please) the survey so that the address shows. Send it to us through your official mail channels.

The upcoming September Safety Day could be a great opportunity to provide us with the information we need. Try incorporating the completion of our survey into your formal Safety Day plans. Safety offices and organizations could make the survey part of their Safety Day agenda. Have all of your people fill out a survey; then collect and mail them to us.

We will read each survey and consider your suggestions; after all, it really is your magazine. This is your chance to sit on our editorial board and have your opinions heard. Help us do a better job of serving you by keeping us on target.

The Combat Edge Staff

- | | |
|--|---|
| 23. Covers | 33. Article thoroughness |
| 24. Layout (professional appearance) | 34. Article variety |
| 25. Article quality | 35. Awards coverage (number and frequency) |
| 26. Photographs | 36. Award write-ups |
| 27. Illustrations | 37. Usefulness in my job |
| 28. Information value | 38. Timeliness of articles/issues |
| 29. Use of color | 39. Accuracy |
| 30. Thought provoking nature | 40. Usefulness in increasing professional expertise |
| 31. Type (size and style) | 41. Attractiveness |
| 32. General interest/entertainment value | 42. Overall value |

42. Has a **Combat Edge** article ever saved your life or kept you from doing something dangerous? If so, briefly describe the situation.

43. How would you rate this magazine in comparison with other publications dealing with the same or similar subject matter?

- | | | |
|---------------------|--------------------|---------------|
| a. The best | c. Average | e. The worst |
| b. Better than most | d. Worse than most | f. Don't know |

Please tell us how you would improve **The Combat Edge**:

What kinds of articles should we print **more of**? **Less of**? **Additions**?

Other comments:

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Branch of Service/Agency _____ Rank _____ AFSC _____ Age _____ Sex: M F

Duty Status _____ Time in service _____ Education (highest level completed) _____

Job title/description _____

1. How often do you read this magazine?
 - a. Very often (every issue)
 - b. Often (most issues)
 - c. Sometimes (some issues)
 - d. Seldom (very few issues)
2. How do you normally obtain this magazine?
 - a. Official USAF distribution (PDO)
 - b. GPO subscription/direct mail
 - c. Library
 - d. Co-worker, associate, friend
 - e. Other
3. How much of each issue of this magazine do you read?
 - a. All
 - b. Most
 - c. About half
 - d. Some
 - e. A little
 - f. Look at but seldom read
 - g. None

4. List the following magazines in your order of preference for reading (which one would you read 1st, 2nd, etc.):

- a. **The Combat Edge** _____
- b. **Flying Safety** _____
- c. **Road & Rec** _____
- d. **Mobility Forum** _____
- e. **Approach** _____
- f. **TIG Brief** _____

Why? _____

5. How soon do you see a copy of this magazine after it is published?
 - a. One week or less
 - b. One to three weeks
 - c. Three weeks to a month
 - d. A month or more
6. What magazines or newspapers do you regularly read?

We are interested in your assessment of **The Combat Edge** magazine. When choosing an answer, write in the number corresponding to the extent you agree or disagree with each statement.

Strongly Agree	Agree	No opinion	Disagree	Strongly Disagree
1	2	3	4	5

- | | |
|--|---|
| <ol style="list-style-type: none"> 8. The Combat Edge satisfactorily presents safety information. 9. The Combat Edge is as interesting as other publications I read. 10. The Combat Edge is as informative as other publications I read. 11. The level of reading in The Combat Edge should not be higher. 12. The articles in The Combat Edge are technically accurate. 13. Overall, the appearance of The Combat Edge is good. | <ol style="list-style-type: none"> 14. Coverage of flight safety issues is adequate. 15. Coverage of ground safety issues is adequate. 16. Coverage of weapons safety issues is adequate. 17. The number of photos, illustrations and charts in The Combat Edge is sufficient. 18. The Combat Edge articles are informative. 19. The Combat Edge articles are interesting. 20. The Combat Edge magazine is useful to me personally. 21. Article topics are in tune with important trends. 22. The Combat Edge is an effective mishap prevention tool. |
|--|---|

For the areas listed below, please rate each using the following scale:

Poor	Fair	Satisfactory	Good	Excellent
1	2	3	4	5

- | | |
|---|---|
| <ol style="list-style-type: none"> 23. Covers 24. Layout (professional appearance) 25. Article quality 26. Photographs 27. Illustrations 28. Information value 29. Use of color 30. Thought provoking nature 31. Type (size and style) 32. General interest/entertainment value | <ol style="list-style-type: none"> 33. Article thoroughness 34. Article variety 35. Awards coverage (number and frequency) 36. Award write-ups 37. Usefulness in my job 38. Timeliness of articles/issues 39. Accuracy 40. Usefulness in increasing professional expertise 41. Attractiveness 42. Overall value |
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| a. The best | c. Average | e. The worst |
| b. Better than most | d. Worse than most | f. Don't know |

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Other comments:

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Official Business

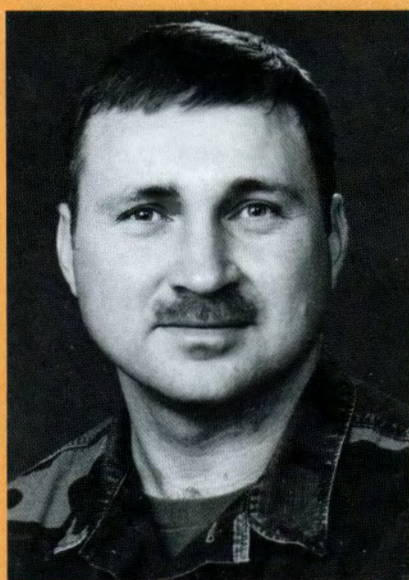
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C
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Weapons Safety Award of the Quarter



MSgt Fisher's dedication to safety is evident in his leadership style. While performing supervisory post lead inspections on aircraft scheduled to fly the next day, he discovered the aft detent of an AIM-9M on the station one LAU-129/A launcher disengaged. The missile had begun to slide aft. Realizing the consequences if not corrected, he immediately notified the weapons expediter who took the appropriate action to correct the problem. Left undetected, the disengaged detent would have allowed the missile to continue sliding aft, resulting in the loss of a training weapon in flight. In addition, he prevented collateral damage to the aircraft along with persons and property below. On another occasion he noticed a



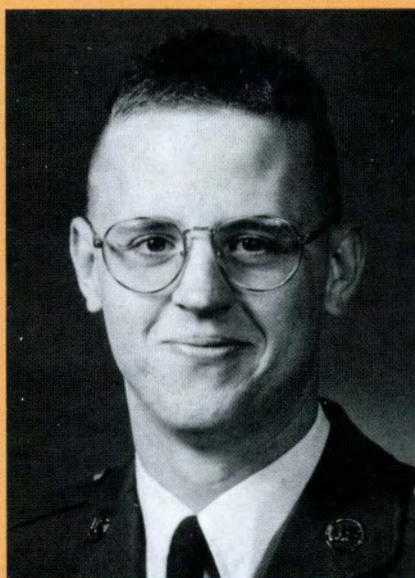
MSgt Philip G. Fisher
4 FS, 388 FW
Hill AFB UT

gun door improperly aligned with the aircraft slipstream. Further investigation revealed the door latches were bent preventing the door from closing flush. He quickly contacted the expediter and the appropriate actions were taken preventing another lost gun door in flight. His attention to detail during another inspection revealed improper bomb rack orifice assemblies installed for carriage of the centerline fuel tank. Knowing the wrong orifices would result in improper tank separation should it be initiated, he quickly remedied the problem before the aircraft was allowed to fly. MSgt Fisher's attention to detail and "keen eye" are indeed valuable assets to the 4th Fighter Squadron's shining safety record.



Ground Safety Award of the Quarter

Airman First Class Long has set the benchmark for our squadron safety program. As the ground radio maintenance ground safety representative, his program was identified as a best seen to date during the Feb 94 USAFAWC annual safety program management evaluation. Shortly after taking over the safety program for his shop, he totally revamped all reference books to ensure work center personnel were well trained. Ever vigilant for potential safety problems, he recently implemented a new safety idea in his shop. He astutely noticed that while performing maintenance, the shop safety board was not always readily available. To eliminate this problem, he incorporated all needed safety items into portable safety kits that can be carried to the job site. This



***AIC James T. Long
727 ACS[T]
Hurlburt Field FL***

type of innovative thinking may have prevented someone from getting seriously injured. Another problem that he identified was that first aid kits were not close-at-hand while working on a remote job site. Had there been

an injury, a life threatening delay in first aid may have occurred. To correct this problem, he obtained first aid kits to carry to job sites during maintenance around high voltage and dangerous jobs. Airman Long has put forth a tremendous effort to have an outstanding program. His drive and self-motivation have pushed a slow safety program to the point that other shop safety representatives consult with him on how to improve their programs.

Airman Long's initiative and effort to bring his shop safety program up to its current level has set the standard for all others to follow. He has put forth a tremendous amount of thought and effort to prevent safety problems before they occur. Such effort is highly commendable and worthy of recognition.



LISTS ARE JUST THAT — CHECKLISTS

When a loading crew is tasked with installing or removing munitions from an aircraft, all the tech data they really need is the appropriate checklist, right? Not necessarily!

If things go "OK" and no problems occur, the checklist will tell you how to perform the task. It specifies actions to be taken in a given sequence to ensure a safe loading or unloading, tolerances to be

met, etc. However, checklists are, in effect, memory joggers; and if you have any problems during the operation, you must go to the -33 loading manual for further information.

Checklists are just that — checklists. If you encounter problems during loading/unloading, get out the -33 and find the answer before you have a mishap or incident. ■

*MSgt Gary Reniker
442 FW/SEW
Richards-Gebaur AFB MO*

WILL HE/SHE KNOW THE GUN IS LOADED?

The old expression "I didn't know the gun was loaded" has often been used too late — that is, as a crutch after a gun-firing mishap has occurred!

In numerous instances the results have been tragic while, in others, only the potential for tragedy existed. One recent incident is a good example.

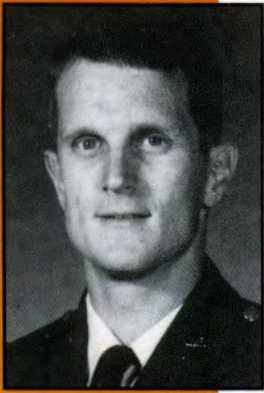
In this instance, several M-16 rifles were shipped from one CONUS facility to another as serviceable weapons for storage. During inspection of the guns at the receiving activities storeroom, one gun was

found with a live 5.56mm round, chambered and ready for firing! The round was removed and nothing happened.

Although the shipment receivers and their inspectors were on the ball, the shippers, including supervisors and inspectors, were definitely not. One wonders what the shipping, supply and weapons inspectors are thinking when a weapons shipment is in progress. Could it be "Will he/she know the gun is loaded?" ■







PILOT SAFETY AWARD OF DISTINCTION

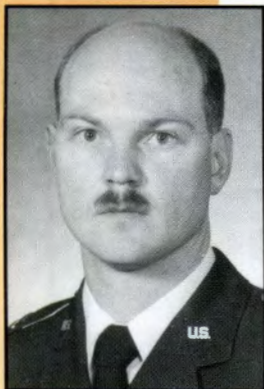
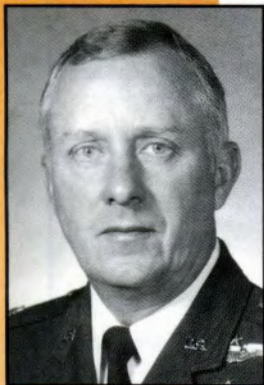
Capt David S. Victorson, 1 RS, 9 RW, Beale AFB CA

"While on closed downwind during a T-38 CPT (Continuation Training Program) training sortie, I realized the need for increased wake turbulence separation from a C-141 on short final. We were at 1500' AGL and about 260 KIAS. To improve our spacing I told the front seat pilot to retard the throttles to idle and select 60 percent flaps. This T-38 was not equipped with a throttle gate; and in his attempt to place the throttles to idle, the other pilot inadvertently placed both throttles to cut off. My attention was on the other traffic

when I heard and felt the engines roll back below idle. Deceleration was rapid and the noise was similar to the sound in the chocks during post flight shutdown. I took the jet and threw both throttles into full afterburner, accomplishing the BOLDFACE for alternate airstart. While watching for indications of nozzle swing and engine restart, I noticed caution lights confirming the shutdown. By this point, the airspeed had bled to 200 KIAS; but restart was rapid with both engines achieving full afterburner. All on board systems were reset and recovery and landing was uneventful."

AIRCREW SAFETY AWARD OF DISTINCTION

*Lt Col Robert B. Brewster, Capt Christopher T. Stewart,
428 FS, 27 FW, Cannon AFB NM*



Lt Col Brewster and Capt Stewart were returning to Cannon AFB as part of an F-111E two-ship on a night instructor pilot upgrade sortie for Capt Stewart. During gear extension for a formation approach, Col Brewster noted that the nose gear indicated unsafe. He immediately assumed control of the aircraft and took the lead of the formation as Capt Stewart began running the emergency checklist. A visual check confirmed that the main gear was down, but the nose gear door was completely closed. The crew headed for the holding fix area and contacted the supervisor of flying (SOF). Despite completing all their checklists and a "Conference Hotel" with Lockheed specialists in

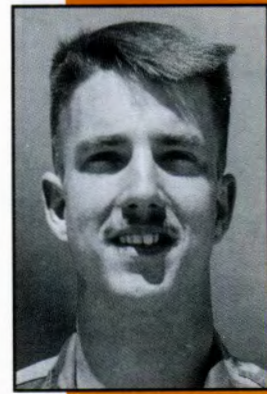
Fort Worth, the crew could not get the nose gear down. As bad weather and gusting winds moved in, the crew set up for an approach end arrestment. Col Brewster executed a perfect landing and approach end cable engagement, then immediately lowered the nose of the aircraft to minimize impact damage from rapid deceleration. After the engines were shut down, the aircrew accomplished an emergency egress. Under extremely hazardous conditions, the quick reaction and teamwork displayed by Col Brewster and Capt Stewart exemplified what today's Quality Air Force is all about. Their skill saved a valuable aircraft and prevented potential collateral damage.

CREW CHIEF EXCELLENCE AWARD

SrA Brian M. Humphrey, 391 FS, 366 WG, Mt Home AFB ID

"During a periodic inspection on an F-15E, I noticed a static leak on the utility suction line under panel 88R. After tightening the line, the leak persisted. I decided to remove the line and inspect the mating face for damage. After removing the line, I noticed the support clamp had chaffed into the line causing severe damage. I also noticed there was no Teflon grommet between the line and clamp to prevent chaffing. I proceeded to inspect another aircraft to see if it had the grommet installed. It didn't. According to the T.O. the grommet was supposed to be

installed. I then reported my findings to the Production Supervisor. With the help of Quality Assurance, the Production Supervisor, and the Tactical Aircraft Maintenance Specialist Flight Chiefs, we initiated a one-time inspection on all aircraft. We found 5 of 13 aircraft with damaged lines, and all 13 aircraft were missing the grommets. With the help of all the Crew Chiefs, all aircraft were repaired in a timely manner. In addition, the 366th Wing's F-15C squadron discovered 4 damaged lines and 7 missing grommets out of 15 aircraft."



FLIGHTLINE SAFETY AWARD OF DISTINCTION

MSgt John E. Tebbets, SSgt Roland H. Jones, Jr., SSgt Carl W. Stover, II, SrA Michael W. Baxley, 416 BW, Griffiss AFB NY

Four members of the 416th Bomb Wing demonstrated selfless devotion to duty by fighting a B-52 wheel fire. On the evening of 7 May 94, MSgt Tebbets, B-52 Production Supervisor, SSgt Jones, Bomb Nav System Specialist, SSgt Stover, Survival Equipment Specialist, and SrA Baxley, EW System Specialist, were on duty on the flightline at Roswell Industrial Airport NM, deployed as part of ROVING SANDS '94. As MSgt Tebbets was leading a B-52 that had just landed to parking, he saw sparks and flames in the rear view mirror of his truck as a fire erupted from the bomber's left forward landing gear. The bomber's aircrew was instructed by radio to shut down the engines and egress the aircraft. Without hesitation, MSgt Tebbets and his companions left the

sanctuary of their vehicle to assist. SSgt Stover and SrA Baxley ran for a nearby set of chocks. SSgt Jones grabbed a Halon fire bottle from its station in front of a parked aircraft and dragged the 150 lb bottle two hundred feet to fight the fire. SSgt Stover helped SSgt Jones free the hose, as MSgt Tebbets pulled the safety pin and SrA Baxley flipped the charging handle to ready the bottle. Upon hearing MSgt Tebbets yell "Charged!" SSgt Jones aimed a stream of Halon at the flames engulfing the brake and wheel and quickly smothered the fire. The fire was later determined to be the result of a brake piston O-ring failure, which allowed atomized hydraulic fluid to spray onto the brake and ignite. Damage to the aircraft was minimal.



GROUND SAFETY INDIVIDUAL AWARD OF DISTINCTION

*TSgt Gregory O. Mayweather, SrA Robert A. Gibbons, II,
27 CRS, 27 FW, Cannon AFB NM*

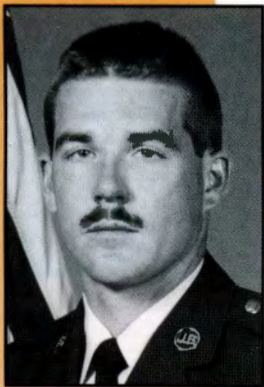


On 2 Mar 94, during a refueling operation at the 27 CRS Test Cell, a fuel valve failed when the refueling truck hose was disconnected from the 5,000 gallon fuel tank. Fuel immediately began spraying out of the four-inch diameter fuel tank valve port. SrA Gibbons and TSgt Mayweather were struck and blinded by fuel spray. They immediately reacted, overcoming the high pressure fuel stream and installing the fuel valve dust cover to stop the fuel spill. Sergeant Mayweather then called the Fire Department and the Component Repair Squadron Supervisor. While waiting, the two had the foresight to

construct a containment dike for the spilled fuel, and assisted the Fire Department in setting up the clean-up operation before being taken to the Emergency Room. Approximately 40 gallons of fuel spilled, with only about 10 gallons reaching the soil that surrounded the cement fuel tank area. Had it not been for their quick reactions, dedication and commitment, 5,000 gallons of fuel would have been lost, and would have reached the 220 volt transformer located 50 feet from the fuel tank. Sergeant Mayweather and Airman Gibbons applied common sense and composure under pressure to prevent a catastrophic event.

WEAPONS SAFETY AWARD OF DISTINCTION

SrA Brian C. Dutcher, 24 MS, 24 WG, Howard AFB PM



On 16 Mar 94, SrA Dutcher was performing a receiving inspection on 15 sticks of dynamite. In the first bag, he noticed one stick was bent, looked wet, and was improperly packaged. Recognizing these discrepancies as critical and potentially hazardous defects, he immediately initiated emergency evacuation and notification procedures. Upon arrival of the Explosive Ordnance Disposal (EOD) team, he showed them the dynamite. EOD determined the dynamite did not present an immediate danger, so Airman Dutcher continued his inspection. Of the 15 sticks, he found 9 were potentially

hazardous. EOD destroyed the hazardous items and Airman Dutcher sent a Report of Discrepancy to the Army depot that had packaged it. He also distributed the report through ACC safety channels so they could warn other munitions storage activities of this potential hazard. Airman Dutcher's strict attention to detail, knowledge of emergency action procedures, and commitment to safety enabled him to detect and correct an extremely hazardous condition which could have resulted in a disastrous explosives accident.

UNIT SAFETY AWARD OF DISTINCTION

388th Maintenance Squadron, 388 FW, Hill AFB UT



The personnel of the 388th Maintenance Squadron excel in the field of safety and maintain a "safety first" attitude always striving for safety improvement! This is evident with a safety record that includes "zero" Class A or B mishaps since the reorganization in Dec 91. They have reduced on-duty reportable Class C mishaps from last year by 66 percent and off-duty Class C reportable mishaps by 70 percent. Additionally, they have not had an explosive/missile Class A, B, or C mishap since the reorganization. The 1994 Annual Wing Safety Assessment revealed an error-free program. The 388 MS takes a proactive approach to safety and has made several changes to increase the safety margin in the daily working environment. Each flight has established environ-

mental goals to reduce exposures to hazardous substances and improve health and environmental safety. Results include reduced lead exposure to Aerospace Ground Equipment troops by 98 percent within the Structural Repair/Corrosion Hangar with the installation of the NILFISK Sanding System. Additionally, they reduced the use of caustic cleaning substances by 80 percent in the Wheel and Tire Shop with the installation of the Jet Washer. A squadron awards program has been implemented recognizing individuals for their contributions to weapons and ground safety. The team effort of the 388th Maintenance Squadron to "think safety" has reduced the risks and protected its most important asset...People.

Accolades

QUESTIONS OR COMMENTS
CONCERNING DATA ON THIS
PAGE SHOULD BE
ADDRESSED TO HQ ACC/SES,
DSN: 574-3814

	TOTAL			ACC			ANG			AFR		
	JUN	THRU MAY		JUN	THRU MAY		JUN	THRU MAY		JUN	THRU MAY	
		FY94	FY93		FY94	FY93		FY94	FY93		FY94	FY93
CLASS A MISHAPS	3	15	16	1	7	8	1	7	7	1	1	1
AIRCREW FATALITIES	4	8	6	4	6	5	0	2	1	0	0	0
* IN THE ENVELOPE EJECTIONS	1/0	12/1	16/0	0	4/0	7/0	1/0	8/1	8/0	0	0	1/0
* OUT OF ENVELOPE EJECTIONS	0	0/1	0	0	0/1	0	0	0	0	0	0	0

* (SUCCESSFUL/UNSUCCESSFUL)

CLASS A MISHAP COMPARISON RATE

(CUMULATIVE RATE BASED ON ACCIDENTS PER 100,000 HOURS FLYING)

ACC	FY 93	2.0	3.1	2.2	1.6	1.7	2.1	1.7	1.7	1.7	1.6	1.6	1.8
	FY 94	0	1.1	1.5	1.8	2.4	2.4	2.0	1.7	1.7			
8 AF	FY 93	0	5.2	3.7	2.7	2.1	1.6	1.4	1.2	1.0	0.9	0.8	2.3
	FY 94	0	0	0	0	0	0	0	0	0			
9 AF	FY 93	6.7	6.5	4.4	3.3	3.9	3.1	2.7	2.3	2.7	2.4	2.2	2.0
	FY 94	0	0	0	2.1	3.3	4.0	3.2	2.8	2.2			
12 AF	FY 93	0	0	0	0	0	0	0	0	0	0	0	0
	FY 94	0	0	2.0	1.6	1.3	1.1	.9	.8	1.4			
DRU	FY 93	0	0	0	0	0	2.8	2.4	4.2	3.7	3.3	4.4	4.0
	FY 94	0	14.9	8.6	6.7	11.2	9.5	7.9	7.0	6.3			
ANG	FY 93	0	2.2	2.9	2.1	3.5	2.9	3.1	2.7	3.4	3.0	3.2	3.3
	FY 94	0	1.9	2.6	2.2	2.7	3.7	3.2	3.4	3.5			
AFR	FY 93	0	0	8.0	5.9	4.8	4.0	3.4	3.0	2.7	2.4	2.2	4.0
	FY 94	0	0	0	0	0	0	0	0	0			
TOTAL	FY 93	1.3	2.7	2.7	2.0	2.4	2.4	2.2	2.1	2.3	2.1	2.1	2.4
	FY 94	0	1.2	1.7	1.8	2.3	2.7	2.1	2.1	2.2			
MONTH	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	

* (HOURS NOT AVAILABLE)

Waivers and Deviations --

DEATH WARRANTS?

MSgt Gary Reniker

442 FW/SEW

Richards-Gebaur AFB MO

Waivers and deviations continue to be used as substitutes for compliance with explosive safety criteria. I personally experienced, some years ago, people attempting to build a children's playground in the explosive safety clear zone area around the explosive storage area. Imagine their surprise and consternation when I explained the unnecessary risk they would be exposing their children to. Needless to say, the playground was relocated.

We must all do our best to plan for and meet the safety requirements before resorting to waivers or deviations. Waivers and deviations are only authorized for operational necessity. Requesting waivers/deviations for convenience of operation or the inclusion of recreational areas in the hazard zone cannot be justified. In some cases unrelated activities and functions have been sited too close to explosives storage facilities. When this happens, we necessitate either reducing the explosives limits or granting a waiver to cover the condition. Changes of the unit mission requiring larger quantities of explosives should be accompanied by a requirement for additional facilities, real estate, etc. A temporary waiver may be required to cover quantity-distance violations until the new facilities are available.

When considering a waiver/deviation, a detailed

analysis of the facilities within the hazard area should be made to determine the full impact of an explosives mishap on the base mission. Mission essential facilities and operations, i.e., control towers, fire stations, command posts, medical facilities and, of course, schools, chapels, theaters, dormitories, athletic fields, and other high density populated facilities should either be relocated or explosive storage arranged to preclude undue risk to these facilities. The cardinal rule of maximum storage consistent with safety criteria is imperative for existing facilities.

Frequent and aggressive explosive safety follow-up during the waiver or deviation period is a must. We must not lose sight of the fact that the hazard exists whether or not a waiver has been obtained. The sooner you can correct known violations and eliminate the need for waivers or deviation, the safer your operation will be. Positive supervision and immediate corrective actions are essential safeguards against disaster. Live munitions are designed to KILL, and they will do just that if required safety precautions are not observed. Remember... "paper barricades" are only additional tools of the trade and require professional use to assure that they do not become... DEATH WARRANTS. ■

OH NO...

Not Another Safety Day!

"What's wrong with those staff puking at headquarters? Do they think we have nothing better to do with our downtime than go through the motions of another Safety Day? For crying out loud, we just had one in May. I thought that Safety Day was supposed to be held after the Christmas/New Year holidays before we get back into flying - so what's going on here?"

These comments recently emanated from the mouth of a wing flight safety officer (FSO) who knew it was his job to set this thing up — an agenda to propose, coordinate, and get approved — memorandums to be drafted and distributed — the logistics of time, place, and briefings to be worked. The plan needed to involve the whole wing: operations, maintenance, and support sides of the house. The frustrated FSO knew it was a lot of work, and they just had that Safety Day in May! So, what is going on here?

Air Combat Command's Office of Safety proposed the formalization of the Safety Day concept as part of a quality effort to meet our established goals of mishap prevention. Approved by COMACC, the idea involved using two critical time frames to focus our attention on the job at hand as well as our off-duty mishap potential. Post winter holiday Safety Days were a common occurrence, but our new efforts will take place in May (prior to summer's 101 critical days) and again in September. September's Safety Day spotlights the end of the fiscal year, reviews the current year's safety performance, and looks ahead to meeting the coming year's safety goals. Our goal is improved safety performance both in the air and on the ground. Why? Because safety is much more than the prevention of mishaps; it is the preservation of combat capability in a climate where every person and every dollar counts.

ACC Safety Days are intended to be proactive. In the recent past, sister services and reserve components have grounded their fleets and held safety days in response to a rash of mishaps. These efforts were certainly warranted; however, they were reactionary in nature. They attempted to stop an existing problem rather than prevent future problems by lead turning them. Our Safety Days are designed to be proactive and prevent future mishaps, not just respond to past mishaps!

Now to the nuts and bolts. You are that FSO in charge of organizing your wing's Safety Day. Where do you start? Or you're the squadron commander in charge of your in-house efforts. What's your plan? Here's our best guess at getting started.

Start by reviewing ACC guidance on conducting your Safety Day. We've sent out several messages leading up to your Safety Day with a general focus and theme, and they list plenty of applicable subjects

"SAFETY DAY GUIDANCE"

1. Thursday, 29 Sep is a XX WG dedicated Safety Day. It involves every unit and every aspect of safety. It is our way of focusing on the challenges that lie ahead of us in the upcoming fiscal year. We need to take a hard look at our past safety record and see where we can make it better.

2. Commanders should start the day in mass by reminding their units of the USAF safety process. We investigate and report safety mishaps solely to prevent them in the future. This is done in the context of confidentiality (Safety Privilege). Sharing our mistakes with one another is the only way we can get the word out. Safety doesn't happen in a vacuum - we must encourage everyone to be open. Safety is not in the business of finger pointing - we want to identify mistakes, not the individuals who made them.

3. Safety Day will be conducted at the squadron level and below. Squadron commanders will divide their units into manageable working groups. Working groups need to focus on the main cause of mishaps - human factors. Not only do human factors cause most mishaps, human factor mishaps are the hardest to prevent. Be honest, be innovative, and we can find ways to prevent a lot of human factor mishaps.

4. Use your afternoon session by having the working groups review our working tech orders, regulations/AFIs, OIs etc. We can make some concrete good come out of this effort. We rarely have the time to stand back and take a comprehensive look at the rules we work under. By using this

time wisely we can change things that need changing. We want to see some 847s producing smarter, safer, and better ways of doing business.

5. Commanders will collect the results of their working groups and be prepared to provide me feedback in a meeting at the end of the day. This will be an informal give-and-take session.

6. Throughout the day, I will visit all units and expand on the purpose and goals of our Safety Day. Please plan on the following times:

- a. 0830 Logistics Group
Hangar 277
- b. 0930 Operations Group
Base Auditorium
- c. 1030 Support Group
NCO Club
- d. 1300 SOF Meeting
Squadron Main Briefing Rm.
- e. 1500 Commanders Review
Officers Club

7. Commanders, please ensure the widest possible dissemination of this letter. Let's make this Safety Day count!

// Signed//

Wing Commander

Footnote: We also found that the success of a Safety Day depends on feedback to the units on the action taken to correct safety deficiencies they identified. Suggest making squadron commanders responsible for providing their people timely and meaningful feedback.

for discussion. Feel free to customize topics to meet your mission needs. Look at what's been done in the past at your wing. If something worked out well, consider expanding it. Call your NAF Safety office and tell them you want some benchmarks they've seen at other wings. Talking about comparisons, here to the left is a plan that was recently used at an ACC wing.

Another idea for a Safety Day activity is to promulgate those war stories. They're heard in every casual bar on Friday nights and have educated generations of pilots. The trouble is that for every jock who learned something from that tail, ten others didn't hear that one. Here's how we can educate the ten who didn't get the word. Have every member of the squadron outline a personal event relating to safety (There I was...) and the lessons learned. Screen these stories by functional level until you have the top three in the squadron. Give those three individuals a computer and tell them to put their story in writing. Forward those stories to wing Safety for review and possible briefing at a safety meeting. For our wing Safety folks - get those stories to us and we'll publish them in our command safety publication, *The Combat Edge*. Then hundreds of people can get the word. One of the most proactive things we can do in safety is to share the lessons learned, otherwise we end up relearning them the hard way.

Don't forget the ground side of safety. Especially since ground safety covers activities both on and off duty. Your choice of approaches to ground safety activities are limitless. Such activities as spending an hour or so identifying and correcting physical hazards in your work areas or going to various work centers and holding open discussions on your philosophy on safety are just two potential activities. You could even center your discussion on the latest trend in mishaps sustained in your unit or base-wide; this information can be obtained through your host base Safety office.

Although taken for granted many times due to the recent successes in this area, weapons safety deserves continued attention because of the ever-present potential for catastrophic destruction. Worthwhile pursuits could be a review of your unit's adherence to Technical Orders and a thorough review of your public safety efforts over the past year. In the weapons business, strict adherence to Technical Order procedures is literally a matter of life and death and must be continually emphasized. Remember that the ultimate goal of Safety Day is to foster a climate of safety in all your unit activities.

The big point to remember is that Safety Day is like anything else — you'll get out of it what you put into it. Have a plan and run it by the wing commander early — getting the word out in advance is a must. It doesn't have to be boring! A little team building activity would be a fine way to conclude your Safety Day. Good luck and have a productive Safety Day.

SAFETY GETS DOWN AND

DIRTY

MSgt Larry Stulz

906 FG/SEG

Wright-Patterson AFB OH

During combat exercises, have you ever sought cover along a sandbag wall or maybe down inside a trench or ditch? Have you ever seen an open trench and taken the opportunity to examine the dirt walls? In combat you have to make the best of the situation; but in peace time, the above places can be extremely dangerous.

Digging a ditch or stacking sandbags has long been viewed as one of the simplest jobs on earth, but it can also be one of the most dangerous. Why? Dirt is heavy. Really heavy! A cubic foot of dry dirt or sand weighs about 88 pounds. Add water and the weight can easily go over 100 pounds per cubic foot.

The next time you have a sandbag lying around (no pun intended), lay it across the end of your hand or arm and try to lift your arm. Hmmm, kind of heavy, isn't it? Now, imagine two or three more, or maybe a whole bunch covering your body. Get the picture? An accidental collapse of trench walls or sandbag walls can crush and kill a person in a matter of seconds. An unprotected person caught by falling soil or sand usually dies from suffocation within 2 minutes due to the immense pressure squeezing the chest and not allowing the lungs to function.

The shallowest trench where a recorded fatality occurred was two and a half feet deep. A welder was lying down next to a pipe when a side trench wall fell inward. That's crazy you say? Time for some simple math. Two and a half cubic feet of stacked dry dirt weighs 220 pounds. Let's say the person's height was 6 feet. 6×220 equals 1,320 pounds. Could you stand up with 1,320 pounds on top of you?

During a recent inspection in our unit, we found a revetment wall of sandbags leaning sideways.

This wall was 3 feet wide, 6 feet high, and 20 feet long containing 31,680 pounds of sand. A potential hazard? You bet! To get a better visual picture of the wall, it was the same weight as sixty-two 500 pound bombs.

Digging a ditch or dealing with dirt and sand is truly a science in itself. It takes days of training to learn all of the OSHA safety requirements and the art of digging a safe ditch. To cover all of the principles would take a book, but here are some of the important safety items:

- * A dirt or sand bag wall begins the cave-in process the split second it is built or dug.

- * OSHA requires that a competent person (a person trained in trench and soil safety) supervise and inspect, at least daily, the condition of trenches and dirt walls (this does not apply to sandbag walls).

- * For stability, sandbag walls should be stacked with a wide base and sloped to a narrow top.

- * All trench walls five feet or deeper must be shored (supported) with engineer designed safety shoring equipment.

- * Plywood should never be used for shoring trench walls.

- * Water coming from trench walls is a sign of unstable soil and immediate danger of collapse.

- * A ladder must be placed into the trench for workers to use.

- * Workers are never allowed to work outside of protected (shored) areas within a trench.

- * Nothing should ever be placed or come within three feet of the edges of a trench (including the spoil or removed soil).

- * NEVER go into a collapsed trench. A trench usually collapses in three stages. The best thing you can do to rescue a trapped person is to evacuate the area and call for assistance. Many rescuers

have died in trench rescues. Do not become a victim yourself. Only enter a collapsed trench when the remaining trench walls have been properly shored by a trained person.

As for sandbag structures, there are no specific guidelines although OSHA does recommend that basic trenching safety standards be applied such as daily inspections and sloping sandbag walls to an angle where the bags will not roll down. Sandbags

themselves can literally explode due to extreme pressures (such as at the bottom of stacks) and weathering or rotting of the sack material.

The best rule to follow is that a trained "competent" person, knowledgeable in the basics of trench and soil safety, always be present whenever a trench is dug or sandbags are stacked. There is a lot more to digging a ditch than is first apparent. ■

SUICIDE PREVENTION

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 5 years ago. At times, it seems like yesterday. Sometimes, 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 takes his own life, his suffering is over. However, the survivor's suffering is just beginning, and believe me, it lasts a lifetime.

*Keele Santiago
Air Force Widow*

NOTHING LIKE A DAY AROUND TH' POOL TO RELAX AN' BEAT TH' HEAT.



PEDO, LOOKS LIKE YOU GOT TH' SAME IDEA 'BOUT COOLING OFF DURING THIS HEAT WAVE.

YEP.



WHERE'S TINY?



HE'S DOWN AT THE OTHER END OF TH' POOL. SAID HE WANTED TO BRUSH UP ON HIS DIVING.



HE MUST BE PRETTY GOOD TO DRAW A CROWD LIKE THAT.

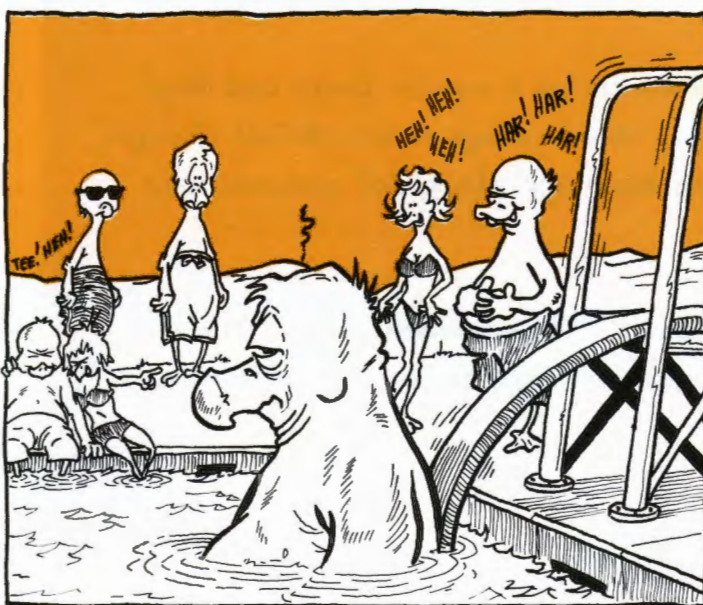


IT AIN'T WHAT YOU THINK. COME ON, I'LL SHOW YOU WHAT I MEAN.



YA' THINK THIS WILL CONVINCE TINY HE STILL GOT A WEIGHT PROBLEM?

MAYBE, BUT I DOUBT IT. HE 'BOUT AS HARD HEADED AS THEY COME.





OUT OF
GAS
IN AN

Aardvark

You Got to be Kidding!

Anonymous

A long time ago in a place far away, I was a Lieutenant who, better lucky than good, narrowly averted a mishap. This story has all the elements of the classic mishap scenario—a chain of events that snowballed into a situation whose outcome could have resulted in the loss of a combat aircraft.

This potential mishap involved such factors as crew rest, discipline, supervisors with "get-home-itus" and "lip service to safety," along with deteriorating weather. Running out of gas in any aircraft is not a good way to distinguish yourself. In an F-111 that holds 32,500 pounds of JP-4 internally, running out of gas would have been committing the cardinal sin of Aardvark attack aviation. As I touched down with 900 lbs remaining, I realized that I'd come within 5 minutes of doing exactly that.

My story starts out in Alaska, a long way from Cannon air patch. We red scarfers were deployed to Brim Frost and having a great time avoiding the adversary air, putting bombs on target and doing the Bush Company. But all good times come to an end and it was time to deploy home. The deployment briefing mentioned a possibility of snow showers at home with the weather steadily deteriorating throughout the day. Our supervisors briefed that, in any case, we would not push the weather! We would not have get-home-itus, and we would land short of our home destination if the weather dictated. The planning and briefing went well. We were scheduled for an early morning takeoff which would require an O-dark-thirty wake up. Any experienced pilot would know that the 6 hour plus, 3,000 mile hop home was not just a routine sortie and that a proper period of crew

rest would go a long way toward making the journey a safe one.

But I was not so much experienced as I was enthusiastic about this TDY — and it wasn't through yet, so off went this intrepid Lieutenant for a night on the town. Mission successful, I returned to the VOQ just in time to realize that my crew rest was not only in jeopardy, but it would be virtually nonexistent. Probably would have to bend that 12 hour bottle-to-throttle rule also. That's all right, I've hacked worse than this.

I remember having the cold chills on taxi out and something kept telling me that I would have been a lot better off sleeping, than launching on a 3,000 mile flight. My WSO, years my senior, appeared not to notice my condition or at least not mention it. Rotating in the preceding Vark's cloud of burnt urea, we flung our 80,000 lbs of mass into the early morning sky. A couple of guys blew the radar trail departure, forcing the entire formation including the tanker to do a 360 to effect the joinup while wasting precious gas. The first few hours were going OK as I snacked on my box lunch to take the edge off my headache. We refueled to toposoff for the remaining portion of the flight, and I did a respectable job of hopping on the boom and getting my gas. With that done, I felt I could coast home and be none the worse for my late night antics. However, we still had a long way to go.

A weather update, with reported conditions of less than VFR at home, was transmitted to the formation by the airborne SOF. We were still three hours away, plenty of time to make a decision to divert if needed. Another hour passed, another weather update and things are getting worse. The ceiling's under 1,000 ft and light snow is falling, but visibility underneath is good — press on! I wasn't very concerned, for I knew we "weren't going to press the weather" and that plenty of suitable divert destinations lay between us and the snow covered high plains of eastern New Mexico. The next weather update didn't sound very good. Ceiling and visibility are being reported at 500 and a mile and a half; funny, that's exactly what Cat C weather category minimums are. As we approach our last divert base, I start to wonder what decision the bosses are going to make. They said they "weren't going to press the weather." It's relatively apparent that the weather is continuing to get worse, or in more precise pilot terms — crump! "I bet we RON at the divert and head home tomorrow," I tell my WSO. But as the DME increases after passing our last divert base's TACAN station, I know they are serious about reaching homeplate. OK, let's get my act together here. I'm dead tired now but all I have to do is an IFR splitup, vectors to the ILS final and put this puppy on the ground. Fuel is fine: 5500 lbs.

Weather update, still calling 500 ft and a mile and a half with blowing snow. As the gaggle of Aardvarks split up, it becomes a real circus up there. I guess this appeared easier than it's actually going to be. It's obvious that the controllers are not used to working this type of mass IMC/IFR recovery (ASLARs didn't exist yet). Aircraft are being vectored all over the place for spacing, wasting valuable recovery fuel. The radios are a mess, with ops checks interrupting controller instructions. My gas is still good, 4500 lbs, and I'm second in line to go down the chute. Boy I'm tired; wish I had gotten a good night's sleep.

The first guy to shoot the approach, a senior Captain patch wearer, breaks out of the weather, lands, but runs off the runway into the overrun, unable to stop on the slick snowy runway. Another vectoring delay as they scramble to get him clear of the runway. OK, my turn now. Looking good, 4,000 lbs of gas and an ILS I could fly in my sleep. Weather reported holding at my weather category minimums. Configure: gear, slats, flaps and down we go. I have it wired passing glide slope intercept altitude. My WSO calls descending through 1,000 ft on the radar altimeter, and I'm anticipating breaking out of the weather any second now. Here's 500 ft, crosschecking for outside references, all I see is the cold gray of low snow clouds. Passing 400 ft, hey- come on now, where's the clear air! Approaching 300 ft, my fun meter is pegged. I'm 200 ft lower than I'm supposed to be on my weather category and still haven't broken out. That's enough

fun for me, burners now as I raise the nose to go around attitude for a missed approach.

Looking back on that approach, I have often wondered if descending another ten feet would have allowed me to break out of the weather; or if I had been better rested, I wouldn't have panicked and used burner on the missed approach. I wonder how low that ceiling actually was and why they kept reporting it at 500 ft. It's history now.

Standard climbout put me on downwind for another attempt at the approach, but I'll need a hole between other recovering Aardvarks. After using afterburner, I had 3,000 lbs of fuel remaining. I think our supervisors finally determined that things were going to hell after the first guy couldn't stop on the runway and the second, me, missed the approach. "No, we won't push the weather!" It was as if they didn't know quite what to do, when a dominating voice came across the UHF. It was the SOF in the tower taking charge of the situation. Three thousand pounds was my response to his question of how much gas I had left. Every suitable divert was now emergency fuel away. His directions were simple and calm: point east south east, perform a max range profile climb, and you are now an emergency, add that last fact to all your calls to ATC. "You are going to Dyess AFB 200 miles away, good luck."

The rest of the Cat C weather category pilots were diverted right behind me, but since I had already missed the approach using burner, I was the low man on gas. Very few people had ever tested the accuracy of the F-111 fuel gauge as

low as I was going to. I flew that divert profile as smoothly as humanly possible and thought about controlled ejection as I watched the fuel gauge wind down. I was trying to concentrate on the task at hand: making it to Dyess' runway on the fumes I had left but the thoughts of why this was happening kept creeping into my thought process. "Boy was that stupid staying out all night, and why the heck did they push the weather when they said they wouldn't?" I felt mad and foolish, but a quick glance at the fuel gauge brought me back to the here and now. Approaching 1,000 lbs remaining coincided with the start of my max range en route descent. An amazing thing happened during that descent. It appeared that the plane was making fuel. The closer I got, the more confident I was that we could make it. We did! Boy, can you aerobrake an Aardvark with 900 lbs of fuel left. The tower controllers got mad at me for scraping my tail bumper all the way down the runway and throwing sparks. I parked the jet and wearily crawled out of the cockpit 7.2 flight hours after brake release that morning. They tell me the guys back at Cannon clapped for us after learning we made it down safely. I was exhausted, but elated that we'd made it down the normal way. No VOQ bed ever felt better than the one I slept in that night.

I learned that even Lieutenants need crew rest. And, if you're a commander out there, did you learn anything? Are you going to push the weather to get home? ■

