"101 CRITICAL DAYS OF SUMMER REVIEW"

The facts are astounding. Forces are drawing down rapidly, bases are closing, and the United States Military is rapidly evolving into a home based force...

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Y 94 was a challenging year for mishap prevention, and ACC was successful in reducing mishaps and thus protecting people and preserving resources in many areas. Our results in both ground and weapons operation improved and allowed us to meet or better our established objectives. ACC experienced 33 Class A ground mishaps equating to a rate of 0.86 (our objective was 0.8) and an 11 percent improvement from FY 93. In the weapons arena, our Class A combined Explosives and Missile mishap rate was 0.4 (mishaps /100,000 flying hours) which was 20 percent better than our established objective of 0.5. Our safety performance in flight operations fell shy of the extremely challenging objectives we had set. The overall ACC rate (mishaps/100,000 flying hours) was 1.9 with 11 Class A mishaps. ACC had 9 Class A command-controlled mishaps for a rate of 1.6. This last statistic is, perhaps, the most disturbing. This translates that over 80 percent of our flight Class A mishaps could have been prevented by someone in the chain of events. Our gained forces (ANG and AFRES) improved their mishap rates in FY 94. The ANG Class A overall rate was 3.3 with a command-controlled rate of 2.6 (7 out of 9 mishaps). Our ACC-gained Reserve forces had an overall Class A rate of 1.3 with zero command-controlled mishaps. Of particular note is the Reserve’s ultimate flight benchmark of zero Class A fighter-attack mishaps. Overall, FY 94 was a good year; but the bottom line from this stakeholder’s report is — we can do better! Particular areas of concern are tech order violations, supervisory involvement, and inattention/lack of focus — things that we are paid to pay attention to!!!

Does not meeting all of our objectives mean that we failed in our mission? Absolutely not! It means that we didn’t do as well as we wanted to. The mishap prevention performance that we are seeking in FY 95 will continue to be valid, attainable, and worthwhile. We have the quality tools, knowledge, desire, and leadership support to embark upon this quest. Can we obtain our objectives this fiscal year? YOU BET! The upcoming holiday season gives us a perfect opportunity to show what we can do. Let’s all work toward preventing mishaps this holiday season by using everything at our disposal. Resolve to adopt a positive attitude, focus on our people, and accomplish the mission!

I need your help as commanders, supervisors, and individual ACC team members to drive our mishap rates and losses to zero — a tough, but achievable goal. I challenge everyone, at all levels, to preserve our valuable resources and protect our people. After all, preserving resources and protecting people through mishap prevention equates to combat capability. Again, work hard, play hard, and above all BE SAFE!

Colonel Fack Acker
Chief of Safety
n the 19 years I have been enjoying helicopters, the novelty of rotary wing flight has never worn off. You can fly fast, relatively speaking (140 kts at 50 feet seems fast). You can hover among things like trees and cliff walls — even canyons. You see things from a different perspective than other people. In all those years I have seen and done many things and have wonderful memories of them. Recently I did something I never thought I would — I survived a helicopter crash — not many people do.

It was a beautiful Sunday morning. My wife and I, in the middle of our morning routine, were interrupted by the phone. The Rescue Coordination Center at Langley Air Force Base called my base Command Post who, in turn, initiated a phone patch for me with the local Sheriff Search and Rescue Coordinator. The Sheriff was conducting a recovery effort for several individuals who were stranded in a canyon. The Sheriff had assessed the situation and determined a “life or death” condition existed requiring a hoist equipped helicopter. In my capacity as the Operations Officer and Acting Commander (the Squadron Commander was...
away from home station), I assembled a Supervisor of Flying and a crew.

The crew, consisting of an Aircraft Commander (AC), Flight Engineer - right scanner, Flight Engineer - left scanner, and myself, the co-pilot, all volunteered to help. The briefings, mission planning, preflight, and run-up were all routine. We launched on the "life or death" rescue mission.

Just after takeoff, the SOF radioed to us that the Sheriff had reconfirmed that a "life or death" hoist recovery was required for three victims — Sheriff rescue volunteers, who were all qualified Emergency Medical Technicians, were suffering from dehydration and exhaustion. We were given coordinates for the rescue base camp, set up by the Sheriff to coordinate the recovery, and told to land there for further instructions. We were 100 nautical miles (40
LOW ROTOR

minutes) away.

En route we calculated power requirements and performed the inflight power checks. We double checked power at various altitudes and temperatures, just to be on the safe side. We determined we would have a 10-15 percent power margin — more than enough for the event. The helicopter’s performance was exceptional.

The base camp was a beehive of activity. Sheriff vehicles, Sheriff deputies, Sheriff rescue volunteers, and a News Channel Jet Ranger helicopter cluttered the large meadow. We checked our power again and reconfirmed that we had a 10-15 percent power margin for the 5,000 foot site. We picked a safe place and landed.

The Sheriff had requested we come to the base camp first so we could pick up a Sheriff rescue volunteer who would show us the way to Hell’s Hole. We briefed our passenger, deconflicted the airspace with the News helicopter, and departed the base camp reconfirming our power margin once again. The rescue volunteer vectored us to the canyon, which was 1 mile from the base camp and 500 feet lower in altitude.

The AC had flown all the way from our home base and, in the interest of sharing scarce flying hours, it was my turn. We spotted the area and I flew a wide downwind to a long final approach from North to South. This afforded the crew an opportunity for a thorough evaluation of the site. After our initial recon, the AC confirmed that I would continue to fly since there were better hover references on my side. The AC and I are both fully qualified Night Tactical Instructors; so it really didn’t matter who was flying, except that there were better geographical features to reference while hovering on the left side of the helicopter — the side I happened to be on that day.

After the recon, the scanners helped us into a 250 foot hover, about 50 feet above the canyon ridge line, 100 yards short of the 3 survivors. From that vantage point we had an excellent view of the bowl (Hell’s Hole) in the center of the canyon. The bowl was open on the north, uphill side, to the canyon above. The south side of the bowl (off the nose of the helicopter) was open, downhill, to a narrow bend in the canyon blocked by a wall of tall trees. A steep cliff wall formed the west side of the bend, and the steep canyon slope formed the east. The east and west sides of the bowl gradually sloped up to the top of the canyon ridge lines. The canyon was about 200 feet deep. The 3 survivors were in the center of the bowl in the bottom of the canyon, stranded on a large rock.

I have been in tighter places, but what was impressive about this place was the rugged surface. There was not one level square inch, it seemed, from the top of the canyon ridges to the bottom of the bowl. The entire canyon was carpeted with scrub brush and large rocks and boulders (some the size of a house). There were tall trees scattered throughout the canyon. While on final approach, I remarked to myself: “no place to land in here if something goes wrong...I was looking at the narrow bend off the nose and a thought bounced through my mind)...maybe there.”

In the past, there have been cases where the hoist cable became disconnected at the fully extended range. The cable is 250 feet long. The crew elected to lower the hover. We checked the power margin and the scanners cleared us down. I gently lowered the helicopter to a 100 foot hover directly over the survivors, 75 yards short of the bend in the canyon where the trees and cliff wall were. The right scanner sent the rescue device down for the first survivor.

Hovering in the bowl, below the ridge line, was not my first choice for a place to be that day. I would have preferred to be home with my wife enjoying a quiet Sunday morning drinking coffee, reading the Sunday paper, and planning our day. The entire crew, I’m sure, would have preferred to be with their wives as well. But, someone had called for our help. The risk was carefully calculated based on the nature of the “life or death” situation as it was presented to us. The wind was calm; we determined there was an adequate power margin — we had no reason not to perform the rescue.

The AC checked our hover power as the survivor cleared
the ground on his way up to the helicopter. We had plenty of power. The left scanner, scanning through the open left cabin door, was ready to assist the right scanner (hoist operator) if needed. The AC was monitoring the hover and performance instruments. I was looking outside at my hover references maintaining our position. The Sheriff volunteer was enjoying the scenery. Just as the right scanner pulled the survivor inside the helicopter, the AC in a composed, matter-of-fact voice, announced: “LOW ROTOR!”

For those of you not familiar with helicopters, the speed of the main rotor, referred to as “rotor RPM,” is critically important. If the rotor RPM is too high, bad things will happen. If the rotor RPM is too low, the helicopter can crash. Rotor RPM is a helicopter crew’s “staff of life.”

I quickly glanced at the tachometer, which was indicating deteriorating rotor RPM, and one-half of a second later looked back out to my hover references. We had lost about 40 feet of critically needed altitude. We were “going down” and there was no place to land due to the sloping terrain and the large boulders. Lowering the collective would flatten the pitch in the main rotor blades, lessening the power demand. However, this action would increase the rate of descent, hastening our impact with the ground. The survivors were directly underneath us. The scanners were posted at their respective positions.

Lowering the collective would have resulted in disaster. Something needed to be done in an attempt to preserve the decaying rotor RPM. I elected to apply right pedal which flattens the pitch in the tail rotor blades, lessening the load on the main rotor. This, of course, caused the helicopter to rotate about the vertical axis (tail left, nose right). At the same time I applied right pedal, I also applied cyclic control in the downhill direction, in an attempt to get the helo above effective translational lift and into forward flight. This could lower the demand on the rotor, and at the same time move us away from the survivors, but toward the trees and the cliff wall at the narrow bend in the canyon. The scanners maintained their scanning positions and announced: “Clear left!” “Clear right!”

With the application of right pedal, the rate of rotor decay decreased. I applied an ever so slight amount of up collective to see if it would fly. The rotor decayed further and the rate of descent increased. The urge to keep the helo airborne caused me to make another application of right pedal. “Clear left!” “Clear right!” came the calls from our scanners.

I saw the trees and the cliff wall which blocked the opening at the bend as we rotated through the second turn. With the low RPM audio still blasting in our headsets, we continued losing altitude. We were going to impact the cliff wall and the trees. There wasn’t enough power for the helicopter to fly, but the remaining 2 survivors on the ground were finally safe from being hit by us.

I looked down over my left boot through the chin bubble and saw what appeared to be a boulder the size of a Volkswagen Bug. With the helicopter still descending, I applied cyclic away from the wall of trees and the cliff wall, stopping our lateral movement, and applied left pedal to stop the rotation. I aimed for the Volkswagen size rock and announced to the crew: “We’re going in!” The rotor had deteriorated well into the “danger zone.” We were going straight down, in a level attitude, with a high rate of descent. The left scanner looked down at the spot and said in a comforting tone: “OK! Looks good!” Everyone braced for impact. The main rotor blades hit the cliff wall. I applied what little up collective was remaining, and there was a deafening explosion as the helo jolted severely to a sudden stop.

We impacted with tremendous force on a level platform of rocks between two ponds at the base of the cliff wall. There was just enough room for the helo — not enough for the rotor blades. They exploded into a million pieces as they struck the cliff wall and the trees — it was a tight little area. There was a large fire at the right front of the helicopter. A 6 foot section of rotor blade was still attached to the rotor head causing an imbalance which resulted in the helo
thrashing about violently on the rocks as the rotor spun to a stop.

The News helicopter was overhead and filmed our crash. From the time the AC announced "Low Rotor" to the time of impact was about 6 seconds. The News helicopter made a distress call and began the recovery effort which lasted nearly 4 hours.

Within those 6 seconds as I was "maintaining aircraft control" the best I could, the AC was attempting to "analyze the situation." He probably had about 3 seconds or so of effective reaction time. Still, he was able to determine that there was no reasonable action he could take. Anything he would have attempted could have altered our descending flight path away from the platform of rocks, which, as it turned out, was the only survivable spot in the entire canyon. Superman could not have done a better job.

The AC egressed through the fire and immediately began fighting the blaze. The right scanner joined him with a fire bottle. They clearly saved us from a catastrophic post-impact explosion.

I couldn’t move my legs due to intense pain from what I learned later was a broken back. My door was twisted and buckled from the impact, so I pulled myself hand-over-hand through a small opening of twisted steel just to the left of the instrument panel. Pulling myself clear, I fell into the small pond below. I saw the left scanner trapped, his right leg pinned between the left cabin door edge and the Volkswagen size rock. Although restrained by his gunner’s belt, he had been partially ejected on impact. The number one engine directly above his head was on fire. Unable to move, I directed the Sheriff rescue volunteer, who, at this point was sitting dazed in the middle of the pond, to fight the fire. I tossed him my helmet and he used it as a bucket to extinguish the fire with pond water.

Department of Public Safety (DPS) helicopters and an H-60 crew from my Rescue Squadron heroically recovered our crew of four and all the other personnel in the canyon. The first survivor (a Sheriff rescue volunteer) and the rescue volunteer aboard our H-60 had minor scrapes and bruises. Our crew was transported to Scottsdale Memorial Hospital. The AC suffered scrapes and bruises and second degree burns on his right leg and foot. He was released to his wife the next day. The right scanner had a sprained left ankle and went home with his wife the next day as well. I was released 10 days later, recovering from lengthy back surgery which involved spinal fusion to repair a crushed vertebrae. The left scanner underwent emergency surgery and lost his right leg just above the knee. He also required three surgeries to repair his severely fractured left foot, broken ankle, and broken right cheek bone. He was released 2 weeks later to his wife and loving family.

Now, 4 months after the mishap, I’m walking about 2 miles each day and enjoying Sunday mornings with my wife more than I ever have in the past. The AC and right scanner took a couple of weeks off and got right back in the saddle. The left scanner, a telephone company employee, is looking forward to returning to work and walking down the aisle with his daughter during her wedding this month.

The 3 survivors we were dispatched to recover were part of a team of 6 Sheriff rescue volunteers sent out earlier in the day to recover a stranded hiker. The hiker and 3 of the rescue volunteers had been recovered by a DPS helicopter about an hour prior to our arrival. We were requested by the local County Sheriff Search and Rescue Coordinator to perform the hoist recovery of the remaining rescue volunteers, reported to be in a "life or death" situation due to dehydration and exhaustion.

Hikers and wilderness users should always be well prepared for their adventure. Proper training, preparation, and equipment will minimize their chances of needing rescue assistance. When responsible officials declare an emergency situation, courageous people standing ready will risk their lives to help. Rescue crews world-wide truly live and die by their motto: "These things we do that others may live."
Here is a typical sample of the many phone calls I receive almost daily. “Chief, I need more manpower; I have a tasking for the desert, one of my troops is scheduled for school, we have an evaluation coming up, plus I have one person taking the early out. I can’t do my job!” Now that is what I hear being said over and over politely over the phone. I won’t go into what is really being thought by the person on the other end of the phone.

Before you ask “Am I going to get more man­ning?” let me answer, “Probably not if you are currently over 70 percent manned.” What I want to share with you is how to get the job done with all the things going on that we might have discussed in that telephone conversation. What I am about to share with you comes from experience, and that’s not 20 years ago at the headquarters, but rather 2. I am putting my wing level hat on to walk you through a process to work smarter.

The first thing you need to do is know your job. What I mean is, do you know what processes are required by public law, Air Force regulations, ACC regulations, and your base regulations/policy? You need to make a list of all the processes which are your responsibility. A good place to find your processes is in the Safety Air Force Manpower Standard (AFMS) 1060B and the Safety Occupational Survey which lists over 300 processes. Your Numbered Air Force (NAF) received a copy via E-mail. Also, use your position description to find any additional duties that may not be listed elsewhere.

Now that you have listed all of your processes, it is time to categorize them by establishing agency and/or level of requirement. For instance:

HAZARD ABATEMENT PROGRAM — Public law
RETRAINING INTERVIEW — Air Force

IN-HOUSE TRAINING — ACC
SEAT BELT CHECKS — Wing/Base

Continue to categorize each and every process until your list is complete.

Thirdly, put all of the public law requirements together, the Air Force requirements, then ACC and lastly the wing/base requirements. Now, starting with your wing/base processes; list the requirements you have that you can no longer accomplish with your present manning and/or method of operation. Then list the ACC requirements that fall into the same category. After a final review of your list, send it to your NAF (DRUs should send their list directly to ACC/SEG). Your NAF will review your list and either approve or disapprove your recommendations. Approved lists will be forwarded to ACC/SEG where they will again be reviewed. After approval, we will provide the list to ACC/IG for use in their future visits. You’re probably wondering why we forward the list to ACC/IG. Well, that one’s easy to answer. Remember, you’re required to receive an evaluation every three years in order to meet public law requirements. Your list helps the IG Team understand your unique situation prior to their arrival for an inspection. If you have an Air Force requirement that you feel is unnecessary, forward it through channels along with your rationale as to why it is unnecessary. However, you cannot stop doing the requirement until it is officially rescinded. Public law requirements must be done until the law is changed/revised/rewritten.

Another way you can help yourself is by bringing that sharp unit safety representative up to help you in the office. You can also work on convincing the retrainee to put in for your base. However, there is no guarantee they will get their choice. The bottom line is we are here to help you. But, you also have to help yourself!
Dressing up your Integrated Maintenance Facility (IMF) bay floor with a polyurethane paint may not always be a good idea. Did you know that there are construction standards for munitions facility bay floors? These standards are normally validated during the design phase and are certified by the Army Corps of Engineers.

In particular, IMF bay floors are constructed with 12-inch thick concrete and reinforced with rebar 6 inches from the surface tied together at the crossings. The surface of the concrete is hardened with a water-based zinc or magnesium fluosilicate mixture. This combination of concrete, rebar, and metal-based hardener has intrinsic properties that make the floor slightly conductive.

Since the IMF maintenance bay is not designated as a hazardous explosive environment, there are no requirements for the floors to be conductive as specified by AFMAN 91-201 (formerly AFR 127-100). The facility is designed with a single point grounding system, and all test stands and maintenance load frames are bonded to that system. So, what’s the point? Just like your body reacts to some medicines, there may be adverse side affects caused by painting your floor. Your floor could be allergic to the type of paint you feed it. You are applying a foreign substance that was not intended to be there and just like your body, it could react negatively. “How?” you ask. Some paints act as a sealer and will not allow static electricity to dissipate into the floor. You may begin to notice an abrupt or unexpected change in the atmosphere. All of a sudden, everyone is getting shocked and you’re wondering why. No matter what you do, you’re always experiencing an undesirable buildup of static electricity. Now you’re concerned about all those electro-explosive devices you work with. Well, constantly having to worry about destroying an expensive piece of equipment due to static electricity buildup is not the best working conditions, but it can happen. So, what are you to do? Use those handling procedures for electro-explosive devices outlined in published technical orders. They are there for this reason.

So what’s the moral of this story? Before you decide to “pretty” up your IMF floor with “pretty” white paint, or any color for that matter, you need to ensure your floor isn’t allergic to it and ends up with a side effect of the “undesirable static electricity build-up” syndrome.
I hope you’ll take what I’m about to say from a friend instead of a Police Officer. See, I’m an Air Force brat. I was born right here on MacDill airplane patch. But I joined the Police Department, so I don’t know which of us made the bigger mistake.”

We’re going to miss that introduction. Corporal Howard Robert “Bob” Northrop, Tampa Police Department, Crime Prevention Division, has been repeating those words during our local orientation briefing for over 11 years. His wit, presence, and outstanding speaking abilities have been the highlight of Course II under the leadership of at least 11 Chiefs of Safety.

It all began back in 1980. Course II attendance was weak and the Safety Office was looking for ways to improve the course. After a call to the local police station, they were put in touch with the Crime Prevention Office. The officers were more than willing to participate and two young policemen started briefing every Friday morning. Soon, they enlisted the aid of another officer to help offset the heavy schedule. Eventually, they brought in a fourth officer, Cpl Northrop. Cpl Northrop took to the program immediately and began volunteering for every briefing — the rest is history.

His briefing consists of information about off-base establishments, bad neighborhoods, home/personal safety/security, laws, local and national news headlines, and plain common sense. Attendees sit mesmerized for an hour, ask pertinent pointed questions, and linger well after the completion of the briefing to make further inquiries. Although we would be hard pressed to find a way to prove a direct correlation, military members in the Tampa Bay Area seem to have a significantly lower incidence level of being victimized. As if giving us two hours of his time every other week wasn’t enough, Cpl Northrop is also a regular participant in Safety Days and Open Houses. He provides displays on gun safety, personal safety, and child identification packages. He brings along a talking police car, Jr. Police badges for the kids, and home security checklists for their parents. Cpl Northrop has been invaluable to our office in investigating traffic accidents and obtaining information in a timely manner. He’s become so much a part of our office that he attends almost every holiday get-together, promotion party, going away luncheon, bar-b-que, etc.

When Bob first began briefing at MacDill, he could tell you exactly how many years and days he had left till he was eligible to retire from the Police Department. He’s since passed that mark and still continues to serve Tampa and the military communities. Unfortunately, we are now counting the days till his last local orientation briefing. Manpower and resource reductions have caused sweeping changes. Quality initiatives have revamped many processes, including how we brief newcomers. With the reorganization of the Right Start program, Course II has been allocated a 20 minute time slot. And, no time has been set aside for off-base briefers. We’ll sorely miss his informative briefings.

On the up side, Cpl Northrop will continue to participate professionally in safety events until he decides to retire. He’ll continue to make special appearances for briefings of TDY personnel when requested. And he’ll continue to be a very highly valued and respected member of the MacDill safety family.
Pilot Safety Award of Distinction

Capt Greg T. Lukasiewicz, 74 FS, 23 WG, Pope AFB NC

Everything seemed normal as Capt "Luke" prepared for an F-16 ACM Instructor Upgrade sortie. As rotation occurred, the proverbial plug came loose. As ATC and his wingman called out that lots of smoke seemed to be coming from the aircraft, he got a “Master Caution” light with an accompanying “Hyd/Oil” warning light on the glare shield. After checking his engine instruments, he confirmed that he had a total “B-System” hydraulic failure. Calling his wingman to rejoin, he reconfirmed the warning lights. Upon joining up, #2 noted that the left main gear was extended, while the nose and right main gear were retracted. Declaring an emergency, he proceeded to High Key to work through the checklist. Utilizing the SOF and his wingman, it became evident that the checklist would lead to an alternate gear extension. Further complicating the matter was that Pope was using Runway 05, requiring Fort Bragg to shut down the range to accomplish the straight-in approach. Alternate gear extension was performed and Capt Luke got a “three green” indication along with visual confirmation from #2. Now he had one last “barrier” to cross—in the F-16, by performing the alternate gear extension, a back-up braking system is implemented, limiting braking application to 75 seconds. Capt Luke flew a flawless approach to Runway 05, touching down on speed. With no nose wheel steering and limited braking, he successfully stopped the aircraft straight ahead on the runway, shut down, and ground egressed.

Crew Chief Excellence Award

TSgt Phillip D. Hudson, 192 MS, 192 FG, Sandston VA

While performing a pre-launch end-of-runway check on the lead F-16C (aircraft 86-0243) of the first afternoon flying cell, Technical Sergeant Hudson noticed a small amount of fuel dripping from electrical wires located in the right wheel well. Sergeant Hudson traced the leaking fuel to an electrical wire harness covered with fuel. Concerned about the unusual location of this fuel leak, he notified the end-of-runway supervisor who immediately aborted the aircraft mission. A subsequent investigation conducted by fuel system specialists revealed a hairline crack in the right side fuel shelf (FS341 Bulkhead). Had this problem not been detected and the aircraft been allowed to launch, fuel could have seeped into the engine bay compartment onto hot bleed air lines, and the aircraft battery, creating an extremely explosive condition. The aircraft has since been grounded awaiting on-site depot repair action. Sergeant Hudson’s exceptional attention to detail, keen situational awareness, and quick thinking, while performing a seemingly routine pre-launch inspection, prevented the potential occurrence of a catastrophic accident resulting in loss of life and destruction of the aircraft.
AIRCREW SAFETY AWARD OF DISTINCTION

Lt Col Michael T. Hennessy, Jr., TSgt Barry L. Wideman, TSgt Timothy M. Nichols
53 AS, 314 AW, Little Rock AFB AR

“We were four hours into a standard C-130 formal training initial qualification sortie at a transition base. Two hundred feet in the air, after one of many touch and goes, the aircraft suddenly shuddered and vibrated. The flight engineer and I quickly scanned the engine instruments, finding no abnormalities. The load master quickly grabbed a flashlight and checked the main gear, finding the inspection windows on the right side covered with fluid and the right forward main gear missing. The flight engineer and load master then removed the inspection windows to get a better view, but still saw no landing gear. We made a flyby of the tower and got another C-130 in the pattern to pass by our aircraft for a visual inspection. We were told our forward gear was dangling by a torque strut and was trailing behind the aft gear. We decided to fly back to home base, where emergency/crash personnel were more familiar with our type aircraft. I landed the aircraft left of centerline with full flaps, anti skid off, and full reverse thrust. During the landing, the dangling tire made runway contact first with a burning rubber smell. I held the remaining right wheel off the ground as long as possible, maintaining directional control with left braking, nose wheel steering, and reverse thrust on the left engines. The aircraft came to a stop on the left side of the runway, and we all egressed with great relief. Preliminary investigation revealed the strut had come apart because a loose bearing nut had, over time, separated from the piston assembly, which holds the gear on when weight is off the wheels.”

FLIGHTLINE SAFETY AWARD OF DISTINCTION

TSgt Mark F. Lacy, TSgt Louis E. Sparks
4 TRANS, 4 EMS, 4 WG, Seymour Johnson AFB NC

During Maple Flag 27, Cold Lake CFB Canada, Technical Sergeant Mark F. Lacy, and Technical Sergeant Louis E. Sparks demonstrated the highest caliber of professionalism by preventing a costly aircraft mishap. On 23 June 1994, Technical Sergeants Lacy and Sparks had just entered the aircraft parking ramp on the east side of hangar 1 when they observed an allied troop disembark a 10K forklift. The driver was unaware that the forklift was left running, in gear, and was proceeding towards a parked aircraft. Sergeant Sparks immediately drove his vehicle towards the forklift enabling Sergeant Lacy to jump from their vehicle and climb on the moving forklift and stopping it approximately 12 feet from the British Jaguar. The quick and decisive actions of these two exceptional NCOs were instrumental in contributing to a successful and mishap-free Maple Flag exercise which included aircraft, equipment, and personnel from five NATO countries.
Airman Attaway was on his way home from work, after a long hot August day on the flightline. He noticed a truck in the parking lot loaded down with a big chunk of dirty and twisted steel. He investigated and recognized the cargo as a severely damaged GAU-8, the A-10 30 MM gun. Upon further investigation he noticed what appeared to be ammunition lodged in the chambers. He discovered that this gun came from an A-10 that crashed several months earlier. It had been trucked over 60 miles and was scheduled to be cleaned and made a permanent static display. He requested EOD assistance to determine if these rounds had been expended or were still live. Due to the damage to the gun from the crash, there was no way to make this determination. After discussion with the EOD unit that safed the crash-site, it was decided the only safe course of action would be to treat these rounds as live and to accompany them on this demolition operation; Airman Attaway volunteered. After detonation by EOD, they determined that these rounds had probably already been fired, but they could not be certain. Before these rounds were discovered, the gun was scheduled for steam cleaning and display preparation the next day. Since 30 MM rounds are percussion primed, the potential for them to fire during this cleaning and subsequent preparation display was high. This would have caused severe injury or death. Airman Attaway could have simply walked by this truck as others had and finished work for the day. His actions extended his work day by several hours, but may have saved several lives.
Learning how to do the job safely and avoiding injury is the function of weapons safety training. The enthusiasm used to get the message across will have a direct effect on what the team players will remember. Effective training programs will change behavior patterns from a casual attitude to a conscientious effort in performing everyday tasks safely. In weapons safety, people need to be convinced that disciplined use of technical orders, checklists and local operating instructions is in their best interest and that this training will ensure absolute protection of critical resources.

This is why monitoring training sessions is so important. If the personal safety pitch is sloppy, the team’s motivation will suffer. A frequent reason for deviations from standards is that somebody forgot! The more you educate and remind people, the less likely they are to forget.

The types of training that need monitoring are:

WORK CENTER SAFETY TRAINING. That safety training conducted by the work section supervisor or by working level supervisors when an individual initially reports for duty. This must cover specific hazards related to the individual’s new duties and work environment.

INITIAL TRAINING. That safety training provided each individual upon arrival which must be completed prior to assignment to a weapons environment.

RECURRING TRAINING. That safety training conducted as a follow-up to initial training. This training must be job-oriented and remind personnel of new weapons safety standards with a review of mishaps to prevent them from happening again.

When team members have been sufficiently trained on safety precautions, the actions learned must be reinforced. The successful team understands the overall mission and the purpose of safety training/practice.
MISHAPS CAN BE PREVENTED
The 45th Reconnaissance Squadron was directed by the Joint Chiefs of Staff to deploy to Misawa AB, Japan, in order to collect important data vital to national security. Due to the high priority of the operation, the squadron was given extremely short notice to move 150 personnel and 50,000 pounds of required AGE, support equipment, and spare parts into place, and to fly operational sorties. This was all accomplished in minimum time, involving four aircraft and zero mishaps.

The aircrews and maintenance personnel performed flawlessly, under a high stress environment where many things could have gone wrong. Maintenance was moving an extraordinary amount of heavy equipment from a new location, since the 55th Wing had just begun operating out of Lincoln Municipal Airport due to runway repairs at Offutt AFB. Not only was the location new, but personnel were working around the clock. The aircrews had show times throughout the early morning hours. All 150 personnel had to bring professional gear, as well as private necessities for a possible indefinite deployment. This gear was all loaded and bussed one hour and fifteen minutes to Lincoln, then unloaded without any injuries or accidents.

Once on location at Misawa AB, the crews immediately entered crew rest to be ready to fly a mission. Throughout the deployment, the squadron flew many missions of extreme complexity and duration (up to 18.6 hours). Including support flights and operational missions, the squadron flew a total of 366 hours in a period of 60 days without any mishaps, all at a strange field unaccustomed to 135 aircraft. Extra vigilance was required by the crews since these missions occurred in congested airspace. These were hazardous missions flown in potentially hostile areas and the crews did not miss a beat.

The ground crews did an extraordinary job of maintaining the aircraft. Because of the number of hours flown, the aircraft had to undergo a contingency phase at a bare base location in field conditions. This was accomplished in minimum time without a single problem. The aircraft were parked with minimum separation on a cramped taxi way meant for F-16s. Due to the skill of the ground personnel and flight crews, not one incident occurred.

Off-duty safety was also superior. On a deployment of this scale, every person becomes very important. If one crew member were to go DNIF, it would require extra coverage by another crew member. Although the crews participated in many events ranging from golf to basketball, no one was injured.

All told, the unit had to operate together to ensure there were no mishaps and the mission was accomplished. It was through everyone’s combined vigilance and dedication to safety that the 45th Reconnaissance Squadron completed the deployment with not one ground personnel injured, no one crew member hurt, and not one single airplane damaged!
As the 86 FWS Ground Safety NCO, Sergeant Bottjen spearheads one of the most successful and enviable safety programs within USAFAWC. He personally briefs current safety issues at all squadron meetings and commander’s calls. He established an excellent Ground Safety read file to be reviewed by personnel who are TOY or who were not present during his briefings. His hard work and dedication were directly responsible for his “OUTSTANDING” rating received for the Ground Safety program and overall “OUTSTANDING” rating for the 86 FWS during the recent USAFAWC Annual Unit Safety Inspection. During the 79th Test and Evaluation Group Safety Day, he coordinated with the local police department for a guest speaker, resulting in a very informative ground safety briefing.

SSgt Stanley G. Bottjen
86 FWS, 79 TEG
Eglin AFB FL

Sergeant Bottjen personally briefs munitions buildup personnel TDY to the 86 FWS for the Air-to-Ground Weapon System Evaluation Program (A/G WSEP) and monitors both buildup and munitions delivery during all evaluations. There have been zero ground safety incidents since his appointment as Squadron Ground Safety NCO. He is currently coordinating with Mountain Home and Elmendorf AFBs concerning munitions buildup and ground safety issues for upcoming off-station deployments. During the recent Joint Camouflage, Concealment, and Deception (JCCD) deployment hosted by our squadron, he was behind the scenes observing all safety aspects of the operation. The results were a flawless exercise. A consummate professional, he conducts and documents monthly ground spot inspections of four separate facilities and is constantly researching and updating his Ground Safety program management books. His dedication to duty and attention to detail are exemplary.
On 23 Mar 94, I was performing an intake inspection on aircraft 80-0208, an A-10A. While inspecting the Electronic Control System precooler, I noticed approximately one-third of the skin area inside the intake was missing. An extensive search was initiated in which a 4" x 1/2" portion of the skin was retrieved from within the precooler intake bay. I proceeded to remove the dog house in order to continue the search for the other missing pieces of skin. A second piece of skin was found once the dog house was removed. At this point, I began putting all the pieces together, much like a jigsaw puzzle. I determined a piece of skin about the size of a quarter was still missing. Further inspection failed to turn up the missing piece. I concluded that the only place the missing piece could be was down the cabin ram air line, which is attached to part of the precooler housing. As a last resort, I used a borescope prior to disassembling the line for inspection. The borescope revealed the exact location of the missing piece. I removed two clamps and a rubber boot, reached into the line, and recovered the last piece of the missing puzzle. If the FOD had not been found, it would have been ingested by the auxiliary Power Unit (APU) when it was started. The APU would have been severely damaged and could have catastrophically failed, further damaging the aircraft and surround equipment.

SSgt James L. Shibley
55 FS, 20 FW
Shaw AFB SC

On 7 Feb 94, the 726th Air Control Squadron, Shaw AFB SC, mobilized their unit in support of exercise “Sea Lion 94-2” (07-19 Feb 94). Over the next three days, 55 tons of combat communications, radar, and support equipment were mobilized into five convoys. On 12 Feb 94, “Convoy 1” departed Shaw AFB SC for the North Myrtle Beach Airport. The other convoys followed in two-hour increments. At 1,000', “Convoy 2” came upon a two-vehicle (civilian) accident. Realizing a potentially dangerous situation, the convoy commander ordered the trail vehicle to remain at the accident scene to assist with traffic management, until law enforcement officials could arrive. The trail vehicle also notified the “Convoy 3” commander and kept him informed of the traffic situation. This action not only prevented the third convoy from driving into a hazardous situation, but also helped to prevent further civilian accidents. On 19 Feb 94, with the exercise over, the final convoy arrived back at Shaw AFB SC. A total of 205 personnel and 91 tactical vehicles traveled 30,000 road miles and not one safety mishap occurred during the two-week period. The overall safety effectiveness of the squadron, during “Sea Lion,” reflects this unit’s thorough training and supervisor involvement, and the consistent use of Personnel Protective Equipment (PPE) such as hard hats, eye goggles, work gloves and steel-toed boots by unit personnel. The personnel of the 726th Air Control Squadron have once again distingushed themselves and the United States Air Force as leaders in safety.

726th Air Control Squadron
20 FW
Shaw AFB SC
During the 1994 "101 Critical Days of Summer" (Memorial Day to Labor Day), Air Combat Command experienced 12 Class A off-duty mishaps. Eleven command personnel lost their lives in 9 private motor vehicle mishaps, and 1 individual died in a swimming mishap. The command also experienced 1 permanent total disability injury when the operator of a motorcycle sustained a fractured back which resulted in paralysis from the waist down.

Although we experienced 12 total Class A mishaps (even 1 death or disability is too many), this is an improvement over the 15 we experienced in 1993. When we look back over the last 5 years, we see a trend of improvement. Despite some ups and downs, we are doing better at protecting our people during the high risk summer season (Fig. 1). This year we had 1 Sports and Recreation mishap (drowning) as compared to 4 in 1993 for a 75 percent reduction. Unfortunately, we had 9 four-wheel private motor vehicle mishaps as compared to 6 in 1993 for a 34 percent increase, and we had 2 two-wheel mishaps as compared to 4 in 1993 for a 50 percent reduction.

Looking at the statistics, it's not too hard to determine where we need to focus our mishap prevention efforts. Of the 27 mishaps that occurred during the 1993 and 1994 "101 Critical Days" 21 involved private vehicle operation — this represents 78 percent of the total mishaps!

The upcoming winter holiday period presents us with both a challenge and an opportunity. We can better serve ACC and protect our people by meeting the challenge of zero Class A mishaps during the winter holiday season. Use the data from the "101 Critical Days" to focus your attention and efforts for mishap prevention during the holiday season. We can eliminate the alarming number of private vehicle caused deaths and serious injuries. By working together, we can prevent the tragedy of death and/or disability from marring what should be a joyous time of celebration. One life lost or impaired is one too many!
You are a Staff Sergeant working shoulder to shoulder with all the other "troops" in the Safety office. You come to work one day and suddenly you are promoted to Technical Sergeant. Almost the very next day the NCOIC goes PCS and the day after that the Ground Safety Manager takes another position across the country somewhere. Now the responsibility for the entire ground safety program rests on your (jeep TSgt) shoulders. And then you realize you're not only responsible for the entire wing's safety program but you're also responsible for several "younger" people who now work for you! Your initial feelings of total inadequacy and fear of failure are mixed with feelings of exhilaration. A chance to prove to yourself and others that you're a professional and that you've got what it takes.

So it begins...the hectic pace of daily life as a wing ground safety manager. Constantly juggling what the chief of safety and higher headquarters expects from you (and your people) and what your people need from you. In the midst of all this, you get the 45 day notice for your QAFA.

This scenario can happen to anyone, and it did happen to me. Having never been a supervisor before was a definite hindrance for me as a Ground Safety Manager. While struggling with my shortcomings as a supervisor, I also discovered, after just a few short weeks, that the way I managed my time had become a real challenge. There were many times I would set priorities for things which needed to be done on a particular day. Of course, it was inevitable that some other HOT project would come along and all my good intentions would be right out the window. Needless to say, the job always required more than eight hours a day. There were many late evenings, some weekends, and I almost never went home without my briefcase. Not only did I feel inadequate as a "boss," but I was off balance most of the time since I was repeatedly asked questions that I didn't know the answers to — the type of technical questions that required a lot of research, coordinating, and writing.

I cannot say with total honesty that my time as a Ground Safety Manager was a roaring success. Rather, it was more a series of small successes and a most definite learning experience.

If you are ever thrust into a position like this, there is one sure thing: "It will happen quickly and if there is one thing you should be, it's PREPARED."

Preparation should begin by gaining as much knowledge as possible — not only technical which is important, but equally important is leadership and management training. Take advantage of any classes offering this type of training. Experience is also a great teacher. By observing the leadership styles of your supervisor you can learn a great deal about how (or how not) to handle a particular person or situation.

Be prepared to spend more time at work; and whenever you're "off balance," remember this feeling is caused by the challenges you're faced with every day. You'll constantly be learning, and this is what makes experience such a great teacher.
### Class A Mishap Comparison Rate

(Cumulative rate based on accidents per 100,000 hours flying)

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* (Hours not available)
Being a safety person is a tough job. It is a “people job” more than a “hazard finding” job because 85 percent of all mishaps can be traced to the unsafe acts of workers and/or to the failure of supervisors.

Here are some guidelines for you to follow as you set out to reduce mishaps:

1. Make sure you have a sound safety policy from your Wing Commander. Know what your boss expects of you. Outline your responsibilities and your authority. Don’t work in the dark!

2. Recognize the need to keep your boss informed. You will need his/her backing when the time comes. Do not expect anyone to simply grant your every wish if you do not show reasons why it makes sense to do what you want.

3. Understand your job. The safety person is not the enforcer of safety rules — the supervisor is! Do not make the mistake of thinking that the entire safety program rests on you alone.
   - It is the job of each supervisor and commander to promote and enforce the safety program.
   - The safety person is a resource person. Your job is to discover flaws in the mishap prevention system, to get hazards identified and controlled and to help the supervisor obtain superior performance from all workers.
   - You are at the peak of your efficiency when you are providing training to the supervisors and commanders so that they can be at the forefront of mishap prevention efforts.

4. The job of a safety person can be tough. You will find yourself bucking tradition, making people feel uncomfortable and sometimes alienating yourself from your fellow workers. But, that goes with the job. It is up to you to cause others to change their behavior and that rarely wins popularity contests. Your ability to develop support for your activities is at least as important as any other task. Keep one thing in mind as you do this:
   - Worry about changing their behavior first — do not worry about changing their attitude. Their attitude will come around, probably, after they have become accustomed to a new procedure and after you have had a chance to provide them with more training.

5. Do not bulldoze over people. Work through them and with them. Respect them and they will respect you. Make sure you know what your objective is and then communicate it clearly. Recognize that supervisors might see you as a challenge to their authority. You can avoid this if:
   - You have the backing and leadership of top management.
   - Management understands that your objective is the Air Force objective — to prevent mishaps, thereby improving efficiency, productivity, and quality.

6. Keep at it. No worthwhile task is ever easily attained. Just when you think you have solved a problem it pops up again. Just keep plugging away. You are in the “people business” now and that means nothing is permanent. Though it is not always evident, it is worth the effort!
A ttitudes! That’s what this is all about — people’s attitudes and symptomatic behavior. The dictionary states that an attitude is a manner, disposition, feeling, position, etc., toward a person or thing.

There are a lot of people out in this great big world, and everyone — man, woman and child — has an attitude. That attitude (good or bad) is formed and developed by a myriad of societal, psychological and physiological factors better left to the shrinks. However, a previously unknown syndrome has been discovered and directly linked with bad attitudes — NCSS. What is NCSS? No Common Sense Syndrome.

Now for some reason it has been determined that this strange phenomenon, NCSS, will most likely show up when there is an attitude shift. An example of this occurrence can be easily given. When you become depressed or sad, or when you are very happy, or when you become very mad (the most common time for this event), what pops up? NCSS!

Associated with this so called attitude shift are some readily apparent abnormal mental and physical symptoms. First, the brain begins to heat up, your pulse rate jumps to about 120, your blood pressure goes up to 180 over 210. Your thoughts begin to roam: “I don’t like that guy. Why do I have to stand in line this long? I’m not letting that car pass, oh no, no way. Man, my boss is a real pain in the @$%. I wish they would get off my back, I know what I’m doing!” Suddenly your eyes begin to bulge, your teeth start to itch, your tongue swells up, and your face turns red, and the pain is unbearable.

It is at this point in time that the logic circuits fail, the attitude goes totally off the scale negative and the mental and physical controls cease to exist. The events that will take place next depend on where you are and what you are doing at the time. For example, if some poor driver wants to pass you and he turns on his turn signal, you must at all costs run him off the road in order to get in front of him (because no one will ever be in front of you)! If you are working around equipment, beware, because you are my next mishap report. I can just see it now. You are sawing a small piece of wood, the guard is not in place, and you say bye-bye fingers. Or what about that drill press; God forbid, you don’t use that jig or goggles. OOPS!!! There goes that metal piece — around and around it goes and where it stops you and I both know. In your throat, your chest, yes, it might even rip your hand right off. Now this first category is category “A,” the low event category. Thankfully, these things only rarely happen.

The second category is the one to be concerned with; these are the day-to-day attitudes. Example: you park by an aircraft, you get out but don’t chock your vehicle. You service equipment batteries, but don’t wear any eye protection. You use grinders with no guards on them; and, of course, the goggles are still hanging on the rack right in front of you. You leave paints and flammables all over the place; don’t forget the dirty oil-soaked rags stuffed somewhere; can what can? Hey man, this is great. I love to wash this aircraft in my tennis shoes, 501 blue jeans, and my favorite tee shirt; this soap that smells like oranges is harmless to me. (If not mixed properly that orange-smelling soap will eat the hair off your arms and make you go blind if you get it in your eyes.) And, of course, there’s my favorite. Who cares if your wife, family, and friends have to yell at 90 decibels just so you can hear them. Those hazard signs don’t mean anything to me (caution, hearing protection required while operating this equipment).

If it is not obvious, I am trying to make a point. Your attitude is potentially the biggest killer of people. If you can tame it and train it, you will be the winner. Taming it will help you physically; your poor body won’t suffer so much abuse. If you train it, you will have a 98 percent chance of preventing or not having a mishap. Remember: A safety attitude is a trained attitude — you must remind yourself daily. Think safety while performing your job and don’t become a mishap report.
As I face the sunset of my two-year tenure as the commander of the 8th Airborne Command and Control Squadron, I’d like to pass on a thought regarding safety and its relationship to being an instructor. I’m sure as you read this, the first thought you have is “groaner,” but do me a favor, give me a little of your time and I promise some food for thought.

We should all understand that the real individual responsible for safety is each one of us, individually and collectively, although we commanders sometimes feel we are solely responsible. Commanders are only the program’s process owners with our unit constituents as our customers. Also, I’ve never met anyone that didn’t agree with their role as safety enthusiasts, although we’re the ones who occasionally experience the mishap.

First, let’s review the immediate relationship between the instructor and the student. The student is usually a new guy (generic term) recently assigned to the unit or one who is in upgrade to a new job. Let’s focus on the new guy because they represent the unit’s future. To all instructors or instructors to be, listen: “What you do speaks louder than what you say!” What this means is the new guy wants very much to not be the new guy; that person wants to be one of the guys ASAP. How does he do that...by emulating, listening, and adjusting his behavior to be everything you say and do. Understand, this includes those things that are not in the training syllabus. The result: Whatever that person is going to be in the squadron is a result of what you are. And what should you be? You should be a professional, empathetic, patient and a safety zealot!...on and off duty. The unit you’re in has established standards — live them! Because what you are is what you create and that is what I get for a squadron. Clearly, commanders invest a great deal in the performance potential of an instructor.

Second, how does all of this relate to safety. Easy. If you’re a true safety zealot, really understand and live safety, then using the formula I described you’ll produce people that we need...people like you, that are safety zealots, well-trained and mission-ready. The bond between the instruction of our personnel and the safe execution of everything we do is the foundation of our unit and represents a most fertile area for continuous improvement.

My message is simple; you the instructor are empowered with a special challenge that impacts everyone you instruct at the basic level. Therefore, you have a tremendous responsibility with equally tremendous results...create safe people who are ready to fly, fight, and win.
Fleagle!

What a day to be airborne.

With all this space t'work in, I think I'll add a few new moves.

Huh! Where did all my altitude go??

It ain't every pilot what can handle a move like this.

Why in sweet Hanna would you try a fool stunt like that, Fleagle?

'Cause th' regs don't say I can't...

CRASH!
It was a 1630L brief for a 1930L takeoff. The helicopter sortie would be long and taxing for all involved. The original plan was a 4-ship low-level navigation route followed by air refueling and ending up with live guns on the range. All in all about 6 hours of fun-filled time on night vision goggles (NVG).

As the crews began arriving for the brief, bump plans were developed to maximize the training accomplished on the sortie. Reports from the flight line began to come in, and in typical fashion our 4-ship shrank to a 2-ship.

We got the weather report and began formulating plan B for the sortie. The night would be warm and the winds calm. But, it was going to be an extremely dark and overcast night. Just another NVG flight with less than optimum conditions; nothing all of us hadn’t seen before.

Planning proceeded and we moved the altitude up from 50 feet AGL to 100 feet AGL. We restricted the formation approaches to large open landing zones. Since this was only training, we took as many other precautions as our collective minds could come up with (for mom and the kids) and started the briefings.

The low-level navigation route included 1 1/2 hours of terrain flight (at 100 feet AGL) and 45 minutes of single-ship and formation approaches to three different landing zones. One pilot required training in single-ship approaches prior to any formation approaches. This became the driving factor for the sequence of events that would follow.

After the briefing and question-and-answer session was over, the rear scanners were cleared out to start the preflight and other preparations. The pilots remained to talk specifics and plan the sequence of maneuvers in each landing zone. The sequence would start with single-ship approaches to two separate landing zones. The landing zones were chosen close to each other to expedite the formation rejoin and conserve fuel.

The pilot who required the single-ship approaches was in the left seat of my aircraft. Our landing zone was 1 kilometer north of the other crew’s landing zone. The other crew had the pilot receiving training in the right seat. Each crew had planned a series of straight-ahead and turning approaches at their respective landing zones.

Each crew was to make approaches into the wind and remain at least 1/2 kilometer apart until all single-ship operations were completed. When the pilot requiring the single-ship work was up to speed, the formation would join-up and head for another landing zone to conduct formation approaches. Everything looked good as it was drawn out on the maps and the white board.

With the briefings and the pre-flight completed, communications checks were made, engines were started, and we were ready for a good sortie. We taxied into position, goggled up, and awaited clearance from tower. After an on-time takeoff we began to leave the blinding lights of the airport behind. We were off to a good start.

The low-level flight to the first landing zone was uneventful for each crew. It was a very dark night and we were proceeding with our collective plan cautiously. The winds were light and variable with the strongest constant indication out of the southwest. I shot the first approach into the wind, landed,
and briefed the crew on the upcoming sequence of maneuvers. We watched the other aircraft do the same in their landing zone.

It was time to start the training approaches we had carefully planned. I gave the controls to the left seater and told him to take it slow and easy since it was extremely dark. He briefed the crew on a closed left hand pattern back for a straight-ahead approach to the same spot. We confirmed the location of the other aircraft prior to takeoff and proceeded.

On downwind we saw the other aircraft take off from their respective landing zone and circle away from us in their own closed pattern. The turn to final took us wide as the pilot acquired the site a little late. The pilot landed in the same location, and we sat on the ground debriefing the approach and briefing the next event. We took off and observed the other aircraft on the ground pointing in a slightly different direction than our own.

The next pattern was much wider to allow the pilot to acquire the site earlier. On downwind for the approach we saw the other aircraft take off in their pattern again. Due to the terrain and the low light levels the pilot again had a difficult time acquiring the landing zone early. He was late enough in the turn that we banked greater than 60 degrees to get lined up and stay out of the other crew’s airspace. We landed, debriefed, and planned the next event.

When we took off this time, our heading had changed enough to require an early crosswind turn to stay out of the other crew’s airspace. Our heading had also changed enough in the previous approaches to align our upwind leg with the other crew’s landing zone. As we turned crosswind we discussed adjusting the pattern, to keep from straying toward the other aircraft. The other aircraft took off after they saw us turn downwind.

The pilot was still having problems picking up references and ended up turning late for final once again. This time we went around to try and set up a better final approach segment. The pilot turned left directly over the top of our landing zone to reorient himself in the pattern. Our scanners were searching for the other aircraft as we established ourselves on downwind. The turn to final was tight and the bank angle exceeded 60 degrees again.

We heard the other aircraft before we ever saw it! My left rear scanner saw the other aircraft in close proximity as it passed our 9 o’clock. Their aircraft was also in a steep turn to establish final for their LZ. We were in a steep turn to establish ourselves on downwind. Each crew had lost track of the other aircraft for a short while at the worst possible time. Each crew had allowed their aircraft to drift closer to the other’s pattern.

Out of 4 crew members on each aircraft only 2 had seen the close call after there was nothing that could be done about it.

I landed my helicopter in the landing zone and discussed the event with my crew. The other crew did the same. Almost simultaneously, the other aircraft commander and I came to the same conclusion. I took the controls, flew to the other crew’s landing zone, and landed. When they were ready, we formed up and headed home.

Between the other aircraft commander and myself we had more than 7,000 hours of experience. This was training and it was now clear that the pilots requiring the training were not learning. They were struggling to fly in conditions that we had seen many times — but conditions that were new to them.

When we went back to the unit and debriefed, it was clearly evident that we had all missed several clues which would have given us an opportunity to correct the situation earlier. We were lucky!

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The facts are astounding. Forces are drawing down rapidly, bases are closing, and the United States military is rapidly evolving into a home based force structured to match a revised national military strategy. The new strategy is a reality for Air Combat Command forces. We are experiencing more rotational forward deployments than ever before. TDY rates are up in nearly every unit as contingency, peace keeping, and exercise taskings reach new highs; and our people and equipment support a myriad of world-wide commitments. As a result of these far flung commitments and increased TDY rates, an interesting phenomena has cropped up — the “deployed mentality” or the “TDY attitude.” Whatever it is called, it is an area of concern for commanders, those deployed, and safety professionals.

Part of the problem with long-term, rotational deployments is the absence of a sense of ownership and differing rules of engagement in the air and on the ground. People deployed to a particular AOR know they will be there for only a limited time and sometimes make the assumption that the rules they follow at home don’t apply. The lack of a sense of ownership can be seen in vehicle maintenance and living arrangements. Conditions that would be unacceptable at home are tolerated or even accepted. This mindset is reinforced when allied forces and host country personnel are seen operating under a completely different set of rules. The differences may be cultural or circumstantial. For example, not everyone in the world operates under the same set of rules when driving a vehicle. Ask anyone who has driven in South America or Saudi Arabia recently for confirmation of this fact.

Another aspect of the problem is workarounds and temporary systems being used in virtually permanent application. This can be seen in cramped living and working conditions, congested flightlines, substandard runways and taxiways, irregular weapons handling procedures, inadequate storage locations, and equipment that is jerry-rigged because of supply shortfalls. All too quickly, these solutions become the norm and “the way it has always been done around here.” People tend to accept the status quo as being safe and effective.

How do we combat these thorny problems? Certainly TDYs and rotational commitments will not go away in the near future. Also, money won’t fall out of the sky to solve these problems. But, there is much we can do. It all starts with...
good pre-deployment planning and commander involvement. Making sure deployment guides are available is the first step. Find out all you can about the AOR before departing. Look into climatology, operating limitations, the local conditions, and any equipment that you’re required to bring. Bring along all the necessary protective equipment to accomplish the mission. Don’t just assume it will be there when you arrive. Get flightline drivers qualified before deploying if the situation dictates.

Commander involvement is critical. Stressing a philosophy of permanence and commitment to safety is especially important. Do this by making risk assessments and appointing interested and energetic safety representatives. Hold supervisors accountable for doing things the safe and smart way. Keep higher headquarters informed of your needs. Remember bad news doesn’t grow better with age. Get your people the required equipment and tools they need to do the job right. Be visible and stay plugged into your people’s concerns.

The culture of safety is strongly imbedded in ACC; but when people are deployed, reminders that the rules still apply are necessary. Safety is meant to enhance mission accomplishment by preserving resources — both equipment and people. Through proper planning and supervisor involvement, people will remain focused. The result is improved combat power — the whole reason we are in business. Make your next deployment a productive and safe one!