

THE COMBAT EDGE

JANUARY 1997



Have a Happy and Safe New Year!

The Combat Edge

AIR COMBAT COMMAND
SAFETY MAGAZINE

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Accent on Safety

accent on safety

Happy New Year! Welcome back from the holidays; glad to see you're back catching up on your professional reading. You know, a couple of weeks ago I was answering one of nature's calls and noticed a copy of the *Edge* lying open on the floor in a stall. Now, you might think that I was horribly offended that our world-class publication was being treated so disreputably. I've got to tell you, I was actually kind of proud. See, to me that incident pointed out that not only was our mag and its message being made available, but people were actually taking it out of the little holder on the back of the door and thumbing through it. (But, I have to admit, I didn't count the pages to make sure they were all there.) Hopefully, we provided our reader with something worthwhile to stimulate the intellectual side of his mind while he was otherwise occupied. You know, it's you, our readers, who make this magazine what it is. You're not only our readers, but also our contributors; so, it's you that keep the articles timely, interesting and meaningful.

In this issue, we've given you some more food for your thoughts on managing risks. The winter months present special challenges which are worthy of particular consideration. Over the last 5 years, we in ACC and our gained AFRES and ANG units have lost 12 aircraft during the month of February. This is second only to August (16 mishaps) as the month holding our greatest risk. Obviously, I ask that you please put on your thinking caps, focus on the jobs at hand and keep our risks under control. Awareness is knowledge and knowledge is power; so, put the power to work for you.

Before I go, let me say again that I'm glad you're taking the time to read our magazine. I hope that it will aid you in your personal efforts to keep us flying, working and living safe. Maybe you'll get inspired to send us your story so that we can share it with others. But, on behalf of janitors everywhere (and at the risk of sounding like your mother), please pick up after yourselves! ■

*Colonel Turk Marshall
Chief of Safety*



THE NEXT LEVEL

*Col Vinnie Noto
HQ ACC/SEF
Langley AFB VA*

Congratulations to all and well done! Air Combat Command enjoyed one of its safest flying years ever, an impressive 1.96 Class A mishap rate for FY 96. I'm sure by now you've read the congratulatory messages from both General Fogleman and General Hawley. I just wanted to add mine to theirs.

Since mid-August, ACC Safety has had a complete change of leadership. The past few months you've heard from our new Chief of Safety, Colonel "Turk" Marshall, fighter pilot, Viper driver and part-time stand-up comic! I'm Colonel Vinnie Noto, your new Chief of Flight Safety, bomber pilot, soon to be Lancer driver and overall "great guy." All joking aside, I'm very happy to be here and looking forward to taking flying safety to the "Next Level!" Before we talk about the "Next Level," let's look at FY 96 and what we as a command have done.

During FY 96, Flying Safety, under Colonel Kid Davee (he still looks like a kid) took

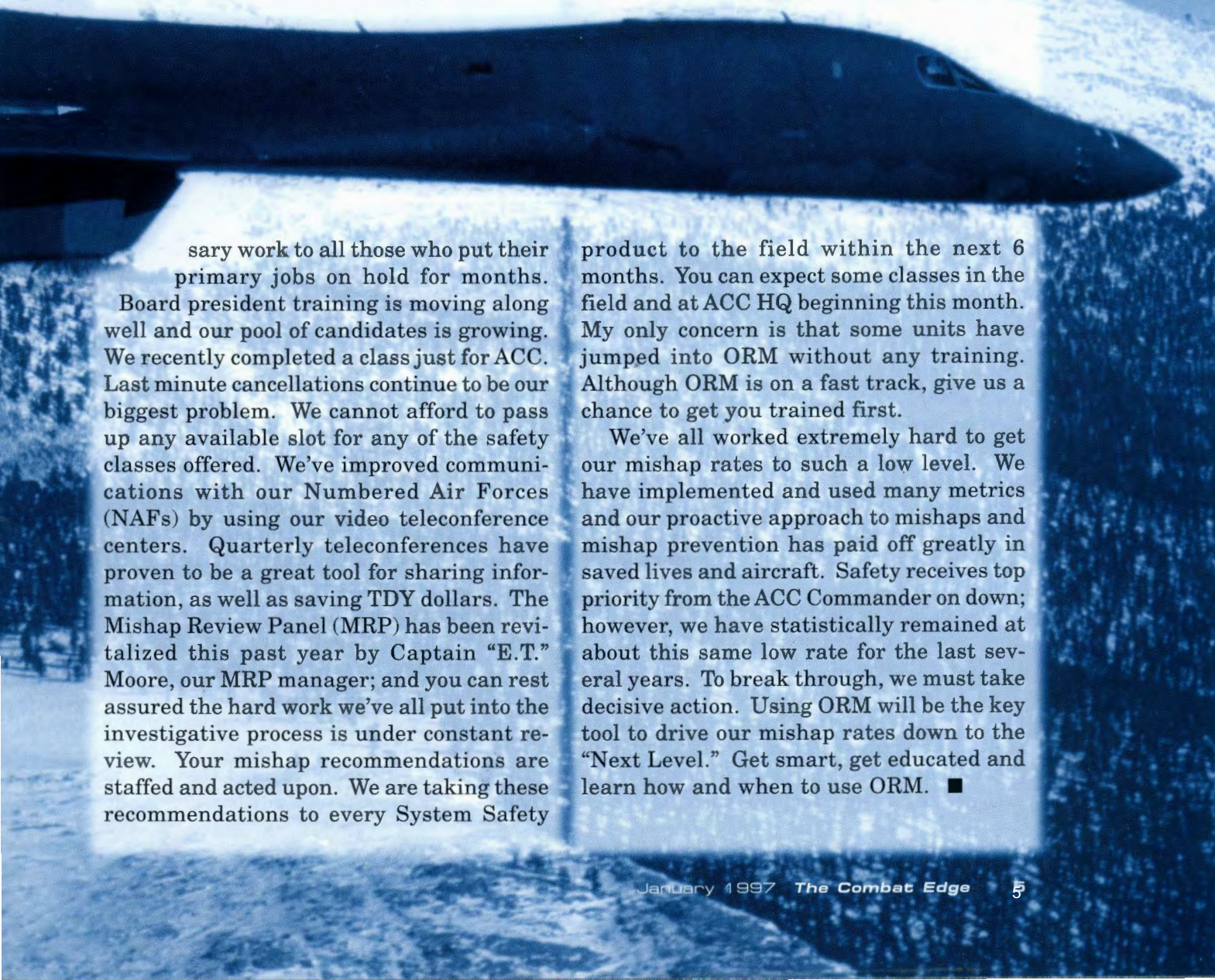
a very proactive lean forward approach to the way we do business. We have virtually completed a visit to every ACC base and reviewed your Bird Aircraft Strike Hazard (BASH) programs. Many significant improvements have been made at most bases, particularly in the intra-base communication and the education of our Supervisors of Flying (SOFs), tower and base ops personnel. We will not rest on these improvements. Most of the problems we found were in the use of the Bird Avoidance Model (BAM) for mission planning and scheduling of low-level operations. Many units did not use the BAM and a few didn't know of its existence. The Ellsworth AFB BASH program was our benchmark program for low-level operations. I'm sure they would be willing to share their results with any and all interested. In the next several

months, we will be working with the AF BASH team to publish guidance and attempt to establish some standards. The HQ ACC BASH working group, run by Major "Duck" Donalds (great name for a BASH guy), has taken on new life; and I expect to see great things from them in the upcoming year. Our Dare County test is complete, and the results are spectacular and are now on CD ROM. Duck can get you the information, just call! Our BASH visits will continue and expect to see us on the road this year, all year.

The Class A mishap briefing process has been going well, and we are holding true to the recommendations of the Blue Ribbon Panel. Our Safety Investigation Boards (SIBs) have shown a great record of well-investigated and well-reported mishaps, a tribute to a great deal of hard and neces-

sary work to all those who put their primary jobs on hold for months. Group (SSG) we attend. Our biggest success, and one that we've talked about before, was ACC's Safety Day in August. Numerous action items from both field units and the headquarters are going through a thorough review. You can expect results early in 1997. I honestly believe these actions will help us maintain our excellent safety record.

To truly get us to the "Next Level," we must embrace the concepts and principles of Operational Risk Management (ORM). A few of you have already been trained and some units are already using some of the basics of ORM in their decision processes. Soon, guidance will be forthcoming which should clear the water on how we will be training and implementing ORM in ACC. Colonel Tom Poole and the ACC staff are working extremely hard to get a usable



sary work to all those who put their primary jobs on hold for months.

Board president training is moving along well and our pool of candidates is growing. We recently completed a class just for ACC. Last minute cancellations continue to be our biggest problem. We cannot afford to pass up any available slot for any of the safety classes offered. We've improved communications with our Numbered Air Forces (NAFs) by using our video teleconference centers. Quarterly teleconferences have proven to be a great tool for sharing information, as well as saving TDY dollars. The Mishap Review Panel (MRP) has been revitalized this past year by Captain "E.T." Moore, our MRP manager; and you can rest assured the hard work we've all put into the investigative process is under constant review. Your mishap recommendations are staffed and acted upon. We are taking these recommendations to every System Safety

product to the field within the next 6 months. You can expect some classes in the field and at ACC HQ beginning this month. My only concern is that some units have jumped into ORM without any training. Although ORM is on a fast track, give us a chance to get you trained first.

We've all worked extremely hard to get our mishap rates to such a low level. We have implemented and used many metrics and our proactive approach to mishaps and mishap prevention has paid off greatly in saved lives and aircraft. Safety receives top priority from the ACC Commander on down; however, we have statistically remained at about this same low rate for the last several years. To break through, we must take decisive action. Using ORM will be the key tool to drive our mishap rates down to the "Next Level." Get smart, get educated and learn how and when to use ORM. ■

ASSUMPTIONS

Is That Worker Really Qualified?

An initial evaluation is required for all newly assigned workers in a work center. The supervisor accomplishes this by reviewing the training records with the individual, discussing the different tasks, and identifying which tasks can and cannot be accomplished by the worker without further training or supervision. A review of the AF Form 55 (Employee Safety and Health Record) from the previous work center will also identify the safety training received and the safety equipment the worker has been issued and trained to use, to include Personal Protective Equipment (PPE). This evaluation helps to identify the worker's expertise, the training he or she has received, and the systems that the worker has used or maintained. The initial evaluation should not be looked at as just another requirement which will eat into the supervisor's valuable time, but as a tool that needs to be used by each supervisor to better manage his or her workers.

During several mishap investigations in the Southwest Asia Area of Responsibility (AOR), the lack of adequate initial evaluations was found to be a problem. In one serious mishap, an individual was dispatched to perform the task of recovering an aircraft following an in-flight emergency. As the ranking person, he was assigned as the team chief. He was a fully quali-

MSgt Robert H. Welsh
9 AF/SEG
Shaw AFB SC



fied 7-level who had been in the AOR for 1 week. Since the shop's workload had been fairly heavy and there had recently been a large turnover in personnel, an initial evaluation had not yet been accomplished. His supervisor was, therefore, unaware that he was not familiar with the particular type of aircraft he was responding to. His actions resulted in costly damage to the aircraft, and he was very fortunate not to have been injured (or worse, killed) in this incident. In another mishap, an individual was operating a special purpose vehicle. He attempted to make a left turn at too high a speed and lost control, rolling the vehicle several times. During the investigation, it was discovered that — once again — the work center supervisor had not

done an initial evaluation. In this case, other documentation showed that training was not a factor, due to the individual having received training on the vehicle at the deployed location. Even though training was not a factor in this particular instance, the question was raised concerning other tasks being performed, possibly by untrained people. And, of course, the mishap probability will always be higher if people are being sent out to perform tasks and work with equipment without proper training. These were just two incidents, but they should not be considered isolated. Many of the minor mishaps which occur are written off to bad judgment on the part of the worker. However, most of these could probably be attributed to training deficiencies.

While most supervisors do perform initial evaluations, often they are not accomplished prior to the new workers going out on the job. Sometimes it is because the supervisor "didn't have the time" due to the hectic work pace in the desert or because the worker failed to carry

his training records to the deployed location.

If you are deploying to the AOR, make sure you carry your training records with you, along with a copy of your AF Form 55, and give them to your supervisor. This is a requirement for all deploying personnel. If you are a supervisor, ensure you review the training of all those assigned to work for you before you send them out on a job. If training records are unavailable for whatever reason, don't assume that the individual knows the job. Assign him or her to work with a trained person until training can be verified by some means. With few exceptions, it is always to your benefit to err on the side of safety. At worst, it may take a little longer to get a job done, but you may be saving the time of having to do it a second time to get it right. It could also avert costly damage to equipment and prevent injury or death. Making the wrong assumption about an individual's qualifications can come back and bite you later on. ■

In Memoriam...

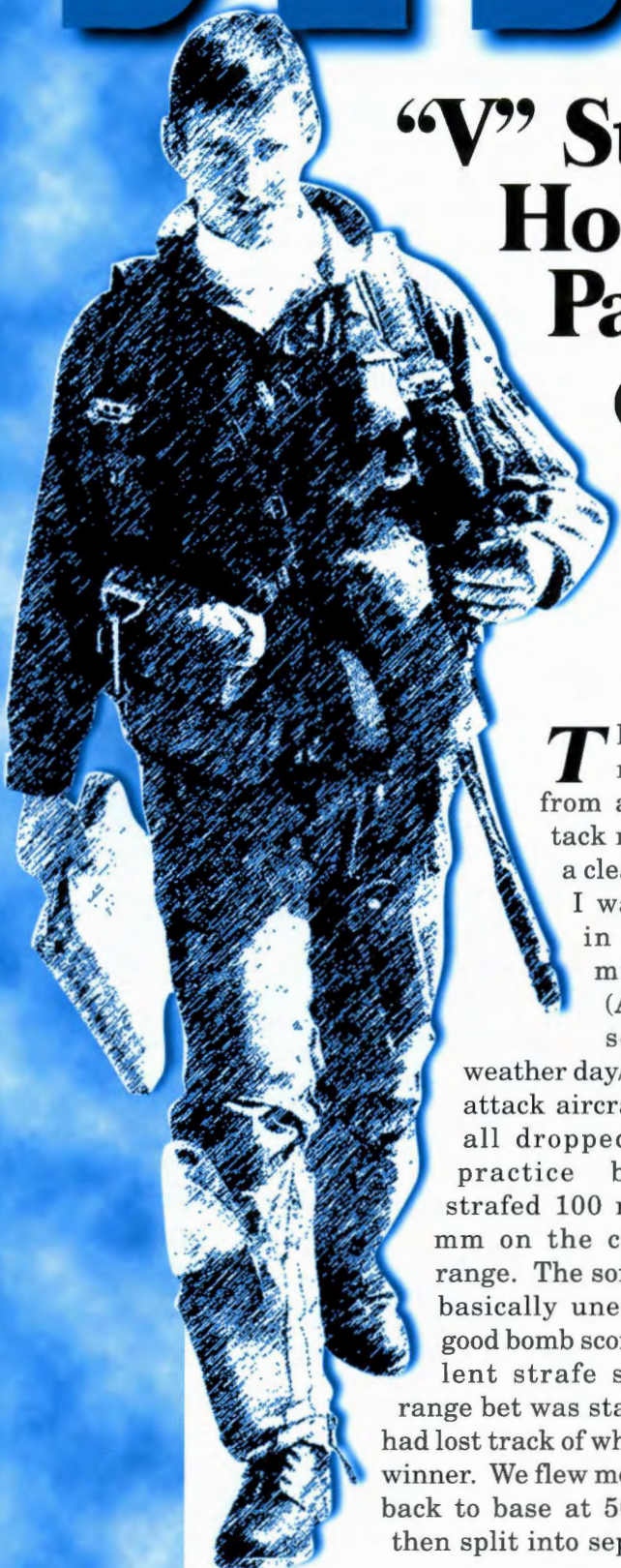
Mr. Michael Mehalko, a safety specialist assigned to the Office of Safety at Headquarters Air Combat Command (ACC), died on December 17, 1996, due to natural causes. During his previous tenure on active duty in the United States Air Force, Mike held several safety positions ranging from Safety Superintendent to Safety Manager. Following his retirement from the Air Force as a Master Sergeant in 1982, Mike was assigned to Langley AFB as a veteran safety specialist in civil service. For the past 11 years, he served as Chief of the Support Ground Safety Section for HQ Tactical Air Command (TAC) and later HQ ACC. In this capacity, Mike was responsible for overseeing the safety and mishap prevention function for all ACC bases, involving over 600,000 personnel, and Air Reserve operations as well. Mike was always a top performer on the job; in fact, he was approved for the Civilian Superior Performance Award for the past four consecutive years. He was a team player and was always there to help someone else in their time of need. Mike was known throughout the Office of Safety as the local on-site automobile mechanic -- when a car wouldn't run, we could always count on him to come to the rescue. A resident of Hampton, Virginia, and former member of the Air Force, Mike had friends throughout the entire military and civilian communities. Due to his outstanding job performance, he became known as the top, ground safety expert within the Air Combat Command. As a result of Mike's dedication and hard work, we all live our lives more safely at home and on the job. Mike is survived by his wife, Carole, and children Michael, Ann Marie, and Julie. His desk is quiet now, but his memory will live on through the lasting contributions he made throughout Air Combat Command in mishap prevention. We will miss him -- a great friend and a true, safety professional.

DEBRIEF

“V” Still Means “Tally Ho” in the VFR Pattern

(or “Watch Out for the Other Guy”)

*Capt Neil MacLauchlan, USAF
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There I was, returning from a surface attack range ride on a clear sunny day.

I was number 3 in a 4-ship of mighty hogs (A-10's — subsonic all weather day/night ground attack aircraft). We had all dropped 9 BDU-33 practice bombs and strafed 100 rounds of 30 mm on the conventional range. The sortie had been basically uneventful with good bomb scores and excellent strafe scores. The range bet was standard, and I had lost track of who was the big winner. We flew most of the way back to base at 500' AGL and then split into separate 2-ship

elements so we could accomplish different approach and landing requirements.

When we arrived back at base, the VFR pattern was busy, as usual. Lead chased number 2 through a simulated single-engine approach and then went out to reenter the VFR pattern. I led number 4 up initial, and tower informed us that we were following a 3-ship of F-111s. I had the F-111s in sight, so we fell in behind them. As they pitched out to land, I called “initial” and tower cleared me to break behind the last F-111. I waited until the last F-111 was abeam me and then I pitched out, with number 4 pitching out 5 seconds later. As I rolled out on inside downwind, I realized the pattern was messed up. I had taken normal spacing (for an A-10 following an A-10), but the F-111s were flying a much wider pattern than the A-10 usually flies. It was no big deal; however, we just angled out on downwind and followed them to base leg. By this time, number 1 had reentered and was on a straight-in 5-mile final approach. Tower cleared him to land following the sec-

ond A-10 on a left base (number 4). Tower was obviously not used to the larger F-111 pattern either, because there was no way number 1 was going to have enough spacing to land behind me and number 4. All



three of the F-111s did a low approach and then stayed right on the deck and did what they do best -- go fast. I landed as the second F-111 pulled closed to inside downwind. The last F-111 pulled closed almost 2 miles beyond the departure end of the runway as number 1 went over me for insufficient spacing. Number 1 requested "closed" and tower cleared him closed "following the third F-111." Number 1 looked over his left shoulder and saw one of the F-111s on the perch, and the second one at midfield downwind; so he assumed the other one had already turned base. Since F-111s are hard to see from the pointy end, he did not see the third F-111 that had pulled his closed 2 miles past the departure end and was still almost a mile past the departure end. Number 1 pulled closed and pitched up right in front of the third F-111. No radio call was made by tower or the SOF (Supervisor of Flying). The next radio call, which was not clear, was the F-111 saying something about "A-10 in sight!" Number 1's hair stood up on the back of his neck, and he rolled out of his bank and picked up the F-111 pointing right at him. He bunted over hard and deconflicted with the F-111, then called that he had the F-111 in sight and was breaking out. No radio calls were made from the tower during this period. All three F-111s landed and number 1 reentered and landed uneventfully.

So, can we learn any lessons from a "close call" like this? Actually, we can learn quite a few. First, there is no replacement for good visual lookout with the old Mark-1 eye balls. We must be ever vigilant and search not only

where we usually see traffic, but also where we seldom see traffic -- especially in the VFR pattern at a very busy base. In this case, it seems everyone involved was conditioned to see what we get used to seeing almost every day -- A-10s in the pattern flying A-10 sized patterns! I pitched out with spacing that would work if following another A-10 -- not an F-111. Tower cleared number 1 to land from a 5-mile final following three F-111s and two A-10s. This might have worked if all five aircraft were hogs flying smaller hog patterns, but it obviously did not work with the F-111s flying a larger pattern and forcing me and number 4 to fly a larger pattern to keep adequate spacing. Then, when the pattern got really stretched out and messed up, tower used the same verbiage they always use, not giving the pilot any indication that the pattern was really stretched out. Perhaps tower should have expanded their call to say, "cleared closed following the third F-111 on downwind, 1 mile past the departure end." This would have given number 1 a heads up that the pattern was messed up and a clue as to where to look for the traffic he was to follow. Lastly, when number 1 pulled closed, someone in the tower should have seen the conflict and made a radio call. Pilots, controllers, and SOFs must all be on the alert for the dangerous situations that can develop so rapidly in the aviation world. We cannot allow ourselves to get "conditioned" to expect the same old thing. We cannot allow "conditioning" to turn a good range ride into a mishap -- nobody wins that range bet. ■



Under Fire

(A Vietnam Story)

Major Jon W. Mabrey, USA (Ret)
39th Supply Squadron
Incirlik Air Base, Turkey

The article below is a true story told by a retired Army helicopter pilot concerning a search and rescue mission he personally experienced in Vietnam. Although the fire fight occurred over 28 years ago, the account provides us with a valuable lesson learned from history that is still pertinent to warfighting and flight safety in contingency operations today. We appreciate a member of a sister service sharing his previous combat experience with us and the steps he took to stay alive while in the jaws of death.

- Ed.

Back in 'Nam about August of 1968 while assigned to the 1st Cavalry Division, I had the dubious honor of giving in-country orientation and familiarization flights for newly assigned helicopter pilots at Camp Evans in I Corps, Vietnam. Earlier that year, I Corps was the scene of the Tet Offensive, the relief of Khe Sahn and the A Shau Campaign; it was still a hot bed of enemy activity. Charlie (the North Vietnamese Army) and US forces were constantly swapping territory along the Lao-tian border and Demilitarized (in name only) Zone between North and South Vietnam.

During this period, a lieutenant named Cole was assigned to our organization. Cole had been in country for about a week, and I was tasked to familiarize him with the area. As was my custom, I took him on several resupply missions in the I Corps area. We had a busy day and were just finishing our missions and heading back to Camp Evans for a cool one when I heard a call on the radio for assistance addressed to any helicopter west of Hue City. Help was needed to rescue a Long Range Reconnaissance Patrol (LRRP) team pinned down in a small area by a superior enemy force. We responded that we were in the area and could assist. After being directed to the area, the following situation was relayed to Cole and me.

Shortly after being inserted into a mountainous region near the Laotian border, the LRRPs came under heavy fire and could not move. Several attempts to extract them failed when several helicopters received hits and were driven off by heavy fire. Now the sun was starting to go down, and the patrol was running out of ammunition. It had become critical that we extract these individuals now or their chances of survival would become very slim indeed. The remaining helicopter originally involved in the insertion was low on fuel and had to leave the area. It was because of this that he was now asking for our assistance.

Flying at high altitude over the area, I quickly found the patrol by the large number of tracer rounds coming out of the Landing Zone (LZ). Sizing up the situation, I determined that a low terrain, high speed approach to the LZ with a quick deceleration was the best and safest way to reach the encircled troops. However, because we would be traveling at high speed at treetop level, I instructed Cole to get on the helicopter controls with me. That way, if I was hit by ground fire, he would be in control of the aircraft and we wouldn't wind up flying into the trees. Lining up my approach, I did a power dive towards the jungle canopy. Straightening out the helicopter just above the treetops, we rushed towards the LZ at the maximum safe speed. Just short of the

LZ, I pulled back on the control stick (cyclic) and applied power to bring the helicopter to a stop just over the area.

It was my plan to quickly drop the helicopter to the ground, pick up the personnel, getting in and out of the LZ before the enemy had time to realize I was even there. The fire-fight was lighting up the LZ, and, so far, everything looked as if it would work out as I had planned. Suddenly, my controls froze and I found myself hovering in a very vulnerable position about 50 feet above the fire-fight. The thought that immediately came to mind was that my hydraulic controls had been shot out, and I was in what commonly was known as "deep kimchi." The real problem became apparent when I looked over at Lt Cole. He was staring wide-eyed, straight ahead, and his hands were locked on the controls. He was experiencing what is known in flying circles as a serious pucker factor. I took my right hand and began to beat on his chest to get his attention. Suddenly, he released the controls and we settled onto the ground.

Without any hesitation, the LRRPs quickly jumped on-board the helicopter, and we expeditiously lifted out of the LZ. Safely in the air and away from the LZ, we all flew quietly back to Camp Evans. It could have been that the North Vietnamese Army thought it was a trick or maybe they were too busy laughing to shoot us down. In any case, no one was hurt, the aircraft wasn't damaged, and Cole and I were both awarded Distinguished Flying Crosses (DFC) for heroism. I guess what happened to Lt Cole could have happened to anyone their first time in a combat situation. Anyway, shortly after this incident, I lost contact with Lt Cole. But I heard he turned out to be a pretty good pilot and later received another DFC for a different act of bravery.

Reflecting occasionally of those days of reluctant glory, I have often wondered how many "Lt Coles" did we lose in similar situations that ended in tragedy? How many other troops were lost as a direct result? We need to train like we will fight, fight to win, and stay alive through it all. ■

SAFETY CAN SAVE LIVES

*MSgt Michael E. Vega
5 OSS/OSOL
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How many times in your Air Force career have you been briefed about safety? I'm sure you have heard the phrase "safety saves lives" and seen plenty of posters about various safety themes. This article is about how the safety program saved four lives in a matter of moments.

Several years ago while I was stationed with the supply squadron at RAF Lakenheath, my warehouse element was tasked to dismantle a storage and retrieval machine (MINI-STACKER). The name of this contraption didn't give justice to its size. The Mini-stacker was not small by any definition of the word, being 24-feet wide, 24-feet deep, and approximately 36-feet high. To give you an example of just how big this machine was, it filled a large aircraft hangar to the ceiling. An engineering company would have charged the Air Force approximately \$5,000 to do the dismantling job, so we were tasked to do it and save the money. After starting the task, I wished the bosses would have contracted the job to the engineering company.

Before we even started the dismantling job, safety was my foremost concern. I informed my flight chief

about the different safety equipment we needed to complete the daunting task before us. We located and acquired lanyards, safety belts, gloves, goggles, and helmets. I gave a safety briefing to all the personnel involved in the project before the work began. I considered the safety briefing with my personnel the most important part of the mission. Personnel were to follow the safety rules completely. No one would be allowed to disregard any safety rule. When a floor supervisor said to clear the area, everyone left the area — no questions asked. We didn't know it, but the safety rules were going to be more important than anyone could have imagined.

We started the dismantling by taking off the outer aluminum siding except at the very back next to the hangar wall. We weren't sure how to get it out from behind the machine and decided to leave it until the last part of the job. The job went well with the huge machine slowly becoming a huge pile of scrap metal. The large uprights were unbolted from the rest of the frame and floor, tied to very long ropes, and safely pulled over to the floor. This procedure was working smoothly, but as usual problems always come up when things seem to be going your way. The last two uprights with the siding on them still had to come down. We decided they could come down together. One of the panels still had the power cables attached to it. No, the power was shut off; I made sure of that. We needed to cut the cables and pull the units down. The support brackets were taken off, and I had one of the personnel hook himself on an 8-foot-high ledge behind the unit next to where the power cables were located. The nuts on the floor bolts were removed, and the go ahead to cut the cables was given. I needed to give a pair of wire cutters to the technician cutting the cable and went into the service doorway of the machine to hand them to him.

As the technician pulled the conduit apart to get at the wires, the machine started to move a little. This machine always moved a little as we worked on it. Two of my personnel were breaking the floor bolts loose from where the other uprights had been, right in the path where the last two uprights would fall. What I didn't count on was the weight of

the siding on the machine at the very back next to the hangar wall. As the floor bolts were loosened, the machine began to move even more and the remaining two uprights started to tip forward without restraint. I immediately yelled to the two technicians on the floor to run. Both of them took off without even looking back. The last two uprights fell around me standing in the doorway, just like a comedy special, ripping the conduit out of the tech's hand and a large power/control box off the wall. I started to turn just as the main power control box ripped off the wall and struck my left shoulder and the side of my head. The uprights just missed one of the technicians running from the area in front of the machine.

Fortunately, no one was seriously hurt. I was bruised a little, and we were all pretty shaken up. The dust from the falling uprights took several hours to settle down again. No one really realized just how close we came to being killed until later that night. This was the type of war story we could tell for years to come. Because of the strong emphasis our team had placed on safety during the dismantling operation, we were constantly trying to do our best to keep alert to any potential catastrophe that might happen. In spite of our oversight in not adequately compensating for the weight of the aluminum siding and its contribution to tilting the last two uprights beyond recovery, our daily focus on safety awareness was our ultimate, standing protection against the unknown. Our emphasis on safety kept us always on guard, prepared us to take action on a moment's notice, and precluded what otherwise would have been a terrible tragedy.

We all talk about safety during our mandatory safety briefings, when we arrive at our new jobs, and at least twice a year on safety days. A lot of times we take safety for granted and feel we are all pretty safe in our jobs and at home. As supervisors, we need to ensure our personnel are safe on the job. Safety needs to be one of the main components of any job we perform. The safety briefing and following the safety rules saved us from becoming a statistic that day. We all went home to our families, alive and in one piece. **SAFETY DOES SAVE LIVES! ■**

REFOCUSED

Captain Tony Monetti, 393 BS/DOV, Whiteman AFB MO

Im sitting in the seat of a B-2 on the return trip to Whiteman AFB after completing a Global Power sortie. The past 36 hours have been filled with hours of boredom and minutes of excitement. The bombs dropped on this sortie, however, will not produce the same effect as the already proven destructiveness of a 2,000-pound Global Positioning System-Aided Targeting System (GATS/GAM) bomb. This mission was a simulation.

The lessons learned from this experience are enormous. I must admit, I wasn't exactly gung-ho about jumping into a "sim" for 36 hours, especially when my New York Yankees were playing Baltimore for the American League Championship. However, I did learn some valuable lessons. Aside from physiological lessons learned, the greatest thing this sim did was refocus my direction. I found myself digging in the books, searching for answers to system problems. I found myself second guessing what the range of a certain threat was or how to do a replanning exercise. The point is, I wasn't concerned about typing hangar fly minutes or creating new aircrew books. The admin jobs will always be waiting on my desk, and my E-mail will always be filled with unread messages. However, when it comes time to drop bombs on the bad guys, I won't wish I had spent more time on the "fluff stuff." My focus needs to be on get-

ting the bombs on target, knowing the enemy, and recognizing my aircraft's capabilities and limitations.

The enormous responsibility placed on our shoulders as airmen cannot be underestimated or forgotten. It is too easy to do that in our environment. I'm not saying that we should not be concerned with the "fluff stuff." We understand there is a need to find balance for our responsibilities. The sad part is that I had forgotten that it was only 5 years ago that I was sitting in the seat of a B-52 dropping bombs against a real enemy with real bullets coming at me and my crew. How could I forget the fear of combat as we attacked the Iraqis at 400 feet at night in the weather? I already experienced the sting of battle and understand what it is to fear the unknown. This sim brought it all back for me. Although I am tired and gruffy, I am grateful for the experience. What an incredible tool we have at our fingertips. Use that sim to its potential. The surface-to-air missiles from the sim won't hurt. The poor decisions made on a bomb run can be replayed. Systems knowledge can be refreshed.

So, as I prepare myself for recovery to Whiteman AFB, I can recall what a wonderful sight it was to see the east coast of America as I returned from the war. As I look out the cockpit of the B-2 simulator and see the lights of the city, I see them through the eyes of a refocused airman. ■



Air Combat Command Office of Safety

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Maj Thomas J. Donalds
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Capt Edward T. Moore
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6181

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ACC Bids



C-130 H

Farewell

"ACC C-130s to join AMC in Spring 1997"

From its inception in June 1992, Air Combat Command (ACC) owned a small number of C-130s in conjunction with the composite wing concept. Effective 1 October 1993, ACC gained the remaining CONUS-based C-130 assets. ACC Herk operators, maintainers, and support personnel have performed the proud mission of providing valuable airland and airdrop capability to commanders worldwide... anywhere, anytime. Thank you for your professionalism, dedication, and sacrifice. Carry on the Herk tradition in Air Mobility Command! Fly safe!

HERCULES

Monthly Awards

PILOT SAFETY AWARD OF DISTINCTION

*Capt Steven M. Burson
358 FS, 355 WG
Davis-Monthan AFB AZ*

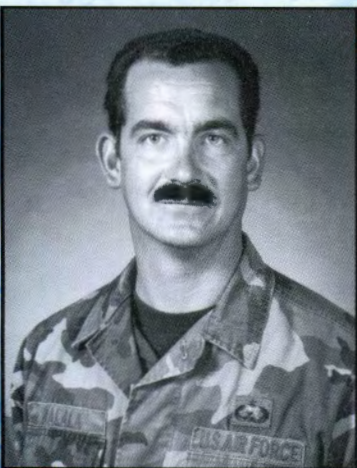
Capt Burson was number three of an A-10 four-ship Surface Attack Tactical Continuation (SAT CT) mission on the East Tactical Range of the Barry Goldwater Range Complex. The mission was a high threat scenario with heavyweight BDU-50s. While performing a turn-level-turn escape maneuver off target at 700 feet AGL, he felt a thump similar to the release of a BDU-50. A scan inside the cockpit to check his armament control panel revealed a flashing master caution and associated right engine overtemperature light. Scanning the right engine instruments, he noted an extremely high Inlet Turbine Temperature (ITT) of 1000 degrees Celsius and low core rpm of 40 percent. He began a climb out of the low altitude environment while retarding the right engine in an attempt to clear the indications of a compressor stall and prevent further damage from the ITT overtemperature. Faced with decaying airspeed, rising terrain, high ambient temperature of 120 degrees Fahrenheit and a heavy ordnance configuration, he elected to push the right engine up to gain any available thrust and jettisoned his remaining BDU-50s. Approximately 2 minutes and 30 seconds later, at a safe altitude of 1500 feet AGL with the right engine indicating 25 percent fan rpm and producing very little thrust, he shut down the right engine IAW checklist procedures. With a non-jettisonable ALQ-131 ECM pod on the right side, the rudder force required to maintain directional control made the 30-mile flight to circumnavigate high terrain physically demanding. Capt Burson executed a flawless single-engine approach and landing to the Gila Bend Air Force Auxiliary Field and ground egressed the aircraft. Further investigation revealed that a stator lever arm from the compressor's second stage had failed, disrupting the airflow over the third stage rotors, resulting in subsequent failure of multiple rotor blades.

CREW CHIEF EXCELLENCE AWARD

*SSgt John E. Balala
71 FS, 1 FW
Langley AFB VA*

After the second flight on 2 Oct, SSgt Balala performed a post-flight inspection on F-15C 82-0019. While conducting the black oil inspection, Sgt Balala noticed the oil sample from the number one engine was unusually dark and emanated a foul odor, similar to burned almonds. Sgt Balala immediately suspected black oil contamination and contacted the Flight Line Production Supervisor. After deliberating with the Production Supervisor, the oil sample was sent to the Component Repair Squadron (1 CRS) Engine Shop. Then 1 CRS personnel performed a preliminary inspection

on the number one engine and oil sample and elected to remove the engine for suspected black oil. The engine was removed from the aircraft and transported to 1 CRS Engine Shop for teardown and inspection. After disassembling the engine, 1 CRS discovered the number five bearing only had approximately 15 more minutes of operation at idle power before total engine failure. Such an occurrence could result in the loss of a rebuildable F100 engine core or the total loss of a multi-million dollar combat asset. Sgt Balala's keen observation skills, technical expertise, and dedication to duty enhanced the safe flying operation of the 71st Fighter Squadron and the 1st Fighter Wing.

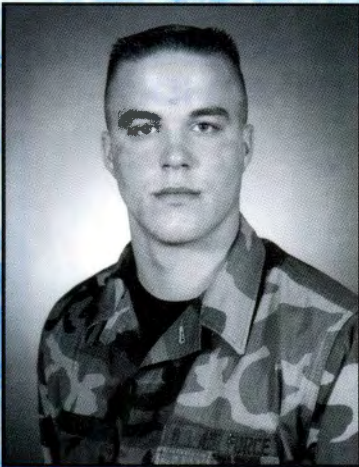




AIRCREW SAFETY AWARD OF DISTINCTION

*Lt Col Donald Swaninger, Lt Col David Moffitt,
Capt Joel Ludwig, TSgt Michael Loechner
SMSgt William Noreik, MSgt Sun Wing Leung
64 AS, 928 AW
O'Hare IAP ARS IL*

On a touch-and-go landing as power was applied, this C-130 aircraft abruptly veered to the left side of the runway. Immediate full right rudder was applied by the instructor pilot, but the aircraft continued to veer to the left. At 100 KIAS, he added nose wheel steering to the right, but they continued to drift left. Unable to stop (approximately 1500 feet of runway remaining) and continuing to drift left toward the left edge of the runway, they elected to take off at 110 KIAS. Shortly after takeoff, the flight engineer called out overspeed on the number one engine with approximately 106 percent and torque less than 1000 inch pounds. Going to mechanical governing had no effect on the overspeed. After maintaining aircraft control to approximately 200 feet AGL, the airspeed gradually increased above 110 KIAS due to the number one engine being virtually inoperative and the aircraft out-of-ground effect. As airspeed continued to gradually increase, the gear was raised and the flaps "milked up" to 20 percent, barely maintaining 200 feet AGL. Once above two engine minimum control speed (145 KIAS) while discussing the shutdown of the number one engine, the aircraft yawed and the engine rpm "broke loose" and returned to normal rpm limits. The number one engine was then shut down and feathered normally. An In-Flight Emergency (IFE) was declared and the aircraft made an uneventful three-engine landing at home station.



FLIGHT LINE SAFETY AWARD OF DISTINCTION

*Amn Michael D. Howard
75 FS, 23 WG
Pope AFB NC*

While working A-10 phase, Amn Howard was tasked with installing access panels on aircraft 80-0204 after a major phase inspection. During the normal foreign object inspection performed prior to all panel installations, Amn Howard noticed a minor deformation in the pitch flight control cable behind panel 24. He immediately notified his supervisor. Upon removal, the actual condition of the cable was brought to light. The cable had been severely damaged. It was crushed and had several broken strands of wire. This rendered the cable completely unserviceable. Although only performing a foreign object inspection, Amn Howard's extra attention to detail led to this discovery which had been undetected by technicians well beyond his skill level. Had Amn Howard not identified or pursued his discovery, it is very possible that the failed cable could have rendered the jet uncontrollable during flight. As a direct result of Amn Howard's attention to detail and professionalism, a future catastrophic mishap has been prevented.



WEAPONS SAFETY AWARD OF DISTINCTION

*SSgt Mark T. Brown, A1C David W. Wade,
A1C George W. Freeman
355 SPS, 355 WG
Davis-Monthan AFB AZ*

During this quarter, A1C Wade and SSgt Brown were involved in training 886 individuals on the M16 rifle, M9 pistol, M60 machine gun, M249 automatic rifle and M203 grenade

launcher without a single safety incident. Approximately 126,000 rounds of ammunition were expended during live fire training. As a true testament to their outstanding instructional abilities and strict adherence to safety practices and procedures, the following incident is especially noteworthy:

On 19 Sep 96, they were involved in conducting live fire for 18 Security Police and Combat Arms Personnel on the M60 machine gun. The class began at 0600 hrs and did not complete training until nearly midnight. The ammunition expenditure for that day alone was 35,000 rounds. About two-thirds through the training, personnel began moving vehicle firing. Amn Freeman was the gunner, Amn Wade was the block officer, and Sgt Brown was the driver and safety NCO. Amn Wade and Freeman acted with text-book exact procedures by pulling the cocking handle rearward within 10 seconds and watching for ejected cartridges. Just 2 seconds into the immediate action procedures, a "cook-off" occurred. The violent unexpected explosion of the round while not fully chambered caused shrapnel to be hurled outside the ejection port. Small fragments cut Amn Wade's face (but not seriously) and small pieces were imbedded into his safety glasses which prevented almost certain eye damage had he not been wearing them. As the airmen were performing the immediate action procedures, Sgt Brown, being made aware of the situation, immediately stopped the moving vehicle safely. He verbally reassured the airmen they were taking the proper steps for the incident. Due to the entire safety focus and team efforts of these three individuals, no one was seriously injured. After the weapon was inspected to recover the lodged bullet in the barrel, the weapon was immediately replaced and firing was continued safely within minutes with no further problems. In this potentially deadly situation, clear thinking and immediate appropriate actions on the part of all members involved prevented a major safety incident and possible injury.

UNIT SAFETY AWARD OF DISTINCTION

*55th Civil Engineer Squadron
55 WG
Offutt AFB NE*



During the last 4 fiscal years, the 55th Civil Engineer Squadron has been working very hard to set up the best Safety Program possible. A computerized data base was developed to track all injuries since Fiscal Year 91, including on- and off-duty injuries. This data base has helped us find trends of problem areas to target during our weekly safety meetings. Thanks to the involvement of key shop personnel as Safety Monitors, we have been able to reach all levels of our work force, both military and civilian, with our safety message. As proof of the success, we are pleased to report a 52 percent reduction for on-duty military mishaps, 34 percent reduction on off-duty military mishaps, and 29 percent reduction for on-duty civilian mishaps with Fiscal Year 92 as a baseline year. The overall reduction in mishaps for the 55th Civil Engineer Squadron of 39 percent shows the commitment that the 55th Civil Engineer Squadron men and women have taken in making Safety the number one priority.



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-Ed.

Mr. Brian Tripp
509 BW/SEW
Whiteman AFB MO

I am asked this question everyday as I move around the wing conducting safety business and I understand why. Not everyone who works to make this wing operate successfully meets with the Nuclear Surety inspectors or participates in generation exercises. It's hard for someone that doesn't work in the Weapons Storage Area or on the flight line to understand how they contribute to nuclear surety.

In order to understand how you contribute, you need to know what nuclear surety is. In reality, nuclear surety is a multitude of programs and requirements directed toward a single purpose — SAFELY MAINTAIN, DEPLOY, AND SECURE THE MOST POWERFUL FORCE KNOWN TO MAN. The Nuclear Surety program addresses the equipment, procedures and methods used to handle nuclear weapons; but most importantly, it deals with people. People are the weakest link in the chain that provides deterrence to all the world's wanna be rulers.

Now, the important part is to understand that everyone in the wing is a shareholder in the responsibility for nuclear surety. Those who are directly involved already know. Especially those involved in the Personnel Reliability Program (PRP). PRP is a method of making certain that the personnel who are directly involved with nuclear weapons remain ready physically and mentally to perform their jobs. How many times have you come to work preoccupied with home and family problems, or feeling drowsy from some over-the-counter cold medication? PRP recognizes that there are times in everyone's lives where we are not capable of giving our best; but when dealing with nuclear assets,

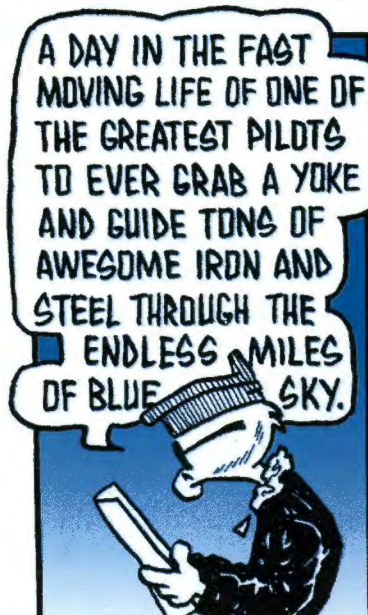
our best is always required. OK, so you tell me that your job doesn't affect nuclear surety because you work in a service organization. You deal with people, not nuclear weapons. That may be true, but the people you support may be the ones who do work with those types of weapons.

There isn't a single person on this base who doesn't contribute directly or indirectly to nuclear surety. Think about it. Your actions in some way affect the people who need to be 100% focused on the safety and security of nuclear assets.

I mentioned earlier the Personnel Reliability Program and the daily distractions that plague all of us. Even if your job doesn't deal directly with nuclear weapons or aircraft, you can still help us maintain nuclear surety by helping those who do. If someone's pay gets messed up, then he or she won't be thinking about their job. The same is true of an NCO who just got a call from his spouse because the water in base housing has been unexpectedly shut off or their child is sick and no one answers at the appointment desk. Even the most basic things like being hungry or cold can have a major impact on a person's ability to concentrate on the job at hand. When concentration wanes, mistakes can occur. People mistakes in the nuclear arena are called personnel errors. The 509th Bomb Wing demonstrated its commitment to eliminate personnel errors through the establishment of a wing goal to reduce them by 10% in 1996.

Remember, when you provide a service to the base populous, you are a part of the nuclear surety program. When you do your very best at whatever you do, you contribute to the **success** of that program as well. ■

Feagle



TACTICS AND SAFETY

A Contradiction In Terms?

Capt Randy Turner
314 OSS/OSTX
Little Rock AFB AR



"Safety is paramount!" Well, not entirely. If safety was paramount, no one would even fly proficiency sorties, let alone tactical training. The objective is to balance safety with the situation. If I remember correctly, the first person killed during Operation DESERT SHIELD was run over by a flight line vehicle on the aircraft ramp at Riyadh AB. In that situation, the proper balance was not achieved and someone died.

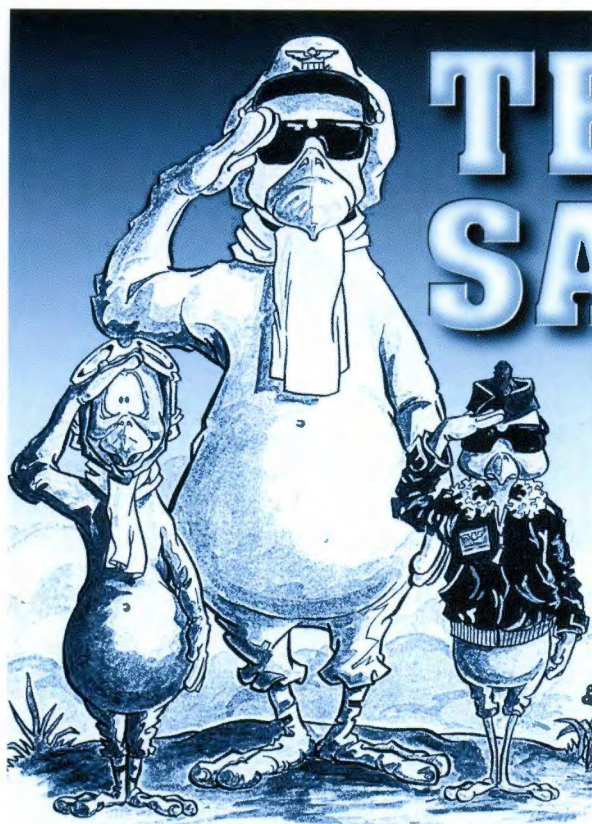
Theater airlift in combat provides C-130 crews with a range of interesting opportunities. We train for a variety of missions ranging from a simple airland of bombs for fighters at a rear area airfield to an airdrop of paratroops or an airland mission on a dirt runway beyond the forward edge of the battle area. This variety calls for something special to prepare the crews for different situations. That would be "judgment."

We in tactical airlift don't have regulations that cover every situation because it would be impossible to write them. The aircraft commander and his or her crew will have to evaluate the situation and decide the smart way of doing things. If you're at a rear operating base and the load team is deviating significantly from standard procedures, one of two things is going on. Either you didn't get a very good threat brief and they know something you don't, or they've lost sight of

reality. A good thought process might be: Is someone shooting at me or will they be soon? Yes — load and go. No — do things as normal and safely as possible.

Once airborne, don't invent stuff as you go along. That's neither tactically sound nor safe. There is no substitute for sound mission planning and reviewing the tested and approved tactics in Multi-Command Manual (MCM) 3-1. There are always situations which arise unexpectedly, but that's why we train. If the unexpected finds you unprepared, your reaction is probably not going to be the tested and proven solution. I heard an ops group commander in the Desert say, "If you do something tactically, you're doing it safely." That's absolutely true. If you execute the appropriate tactic for the given situation, you're doing the mission as safely as possible.

In the C-130 theater airlift world, things aren't always standard, especially in combat. We have a lot of tools we use to get the job done. We fly low level, we fly high level, we land on dirt, we land on concrete, we drop personnel and equipment from high altitudes or low altitudes. These are all tools or tactics we use. The same applies to safety — it's a tool we use to get the job done. If we use good judgment and balance it with the situation, we won't lose anybody to stupidity in the process. We try to defeat the enemy by using sound tactics, and safety goes hand-in-hand with that objective. Let's not lose any more folks to ground mishaps or experimenting with tactics in a non-threat environment. You don't win by doing the enemy's job for him. Be tactical and safe. ■



TEAM SALUTES

ACC/SE salutes the following composite team of airmen who, while assigned to the 4404th Provisional Wing, demonstrated outstanding competence and professionalism while successfully handling a serious in-flight emergency.

Col John Rivers
 Lt Col Paul Sparkman
 Maj Jim Fitch
 Maj Neil Catone
 Capt Bret Thunnel
 Capt Jim Edlefsen
 Capt Dennis Garrett
 Capt Royce Eves
 Capt Mike Majority
 Capt Skip Pribyl
 Capt Phillip Barks
 Capt Carl Rahn
 1Lt Dave Lenderman
 1Lt Tom Hermel
 SSgt Alex G. Marsha
 SSgt Jeffrey A. Langer
 SSgt Kenneth J. Hobby
 SSgt Rodney Smith
 SSgt Stephen Yantko
 SSgt Pernell Foster
 SrA Timothy J. Enright
 A1C Bill Fitch
 A1C Amanda Pearson

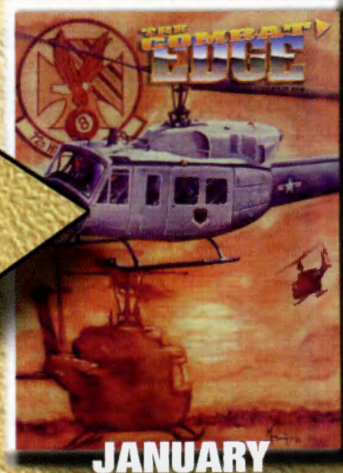
On 11 Oct 96, Gulf 01 flight was returning to Prince Sultan AB (PSAB) from an Operation SOUTHERN WATCH mission. While configuring for landing, Gulf 02's left main landing gear did not extend. Gulf 01 inspected number two's left Main Gear (MG) and found it up and locked, with the MG doors open about 3 inches. With only 2,300 pounds of fuel, Gulf flight declared an in-flight emergency and asked air traffic control to find an airborne tanker. Mako 23 (a KC-135 on approach frequency) swiftly recovered to PSAB while Gulf flight attempted to extend the gear.

As Mako 23 refueled Gulf flight overhead PSAB, the SOF coordinated with the Command Post to find another tanker; duty officers directed Mako 21 to prepare for emergency air refueling. Squadron Top 3 confirmed Gulf flight was refueling, briefed wing leadership of the situation, had the SOF initiate a conference call with McDonnell Douglas, and reviewed Dash One procedures with Gulf flight.

As twilight fell, the flight considered jet-tisoning ordnance and accomplishing an approach-end arrestment on the right main and nose landing gear, IAW Dash One procedures. Top 3 directed Gulf 02 to accelerate to 350-400 KIAS (increasing "G" available) and "pulse" the stick in a last-ditch attempt to free the left main gear. As Gulf 02 accelerated through 330 KIAS, the left main gear extended; Gulf 02 landed uneventfully from a Precision Approach Radar (PAR) approach. An out-of-rig gear door control rod on the left main gear up-lock mechanism caused the problem. ■

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JANUARY

Editor's note: The following index of articles is provided in an effort to make it easier for our readers to tap the reservoir of knowledge contained in The Combat Edge. We receive numerous requests throughout the year concerning past articles or artwork. Many times, the requests are quite vague concerning title, author, subject or issue and often necessitate laborious research through past magazines. This index was compiled so that The Combat Edge could continue to be a valuable source of information to our readers.

Index entries are listed alphabetically by title in the following format:

TITLE

Subject synopsis

Author/Artist - Date, Safety discipline
(if applicable)

We solicit your comments and suggestions concerning the index (or The Combat Edge in general) so we can better serve our readers. Send us a note or give us a call. Our address, phone number and E-Mail address are inside the front cover ■

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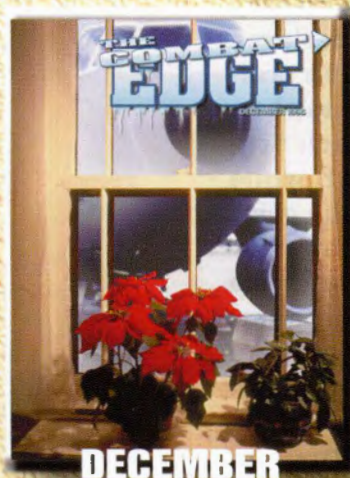
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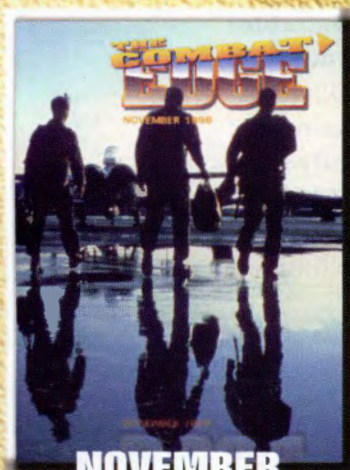
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ACC/SE Organizational Chart

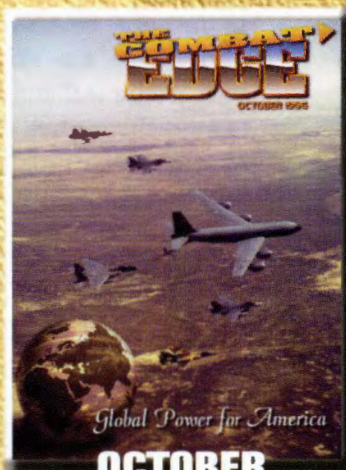
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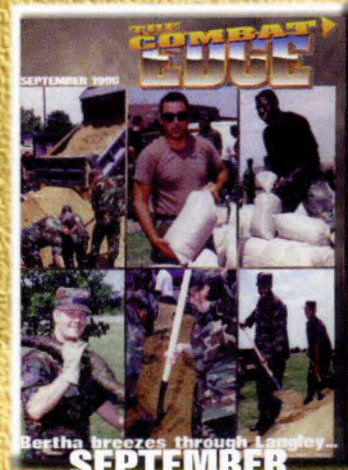
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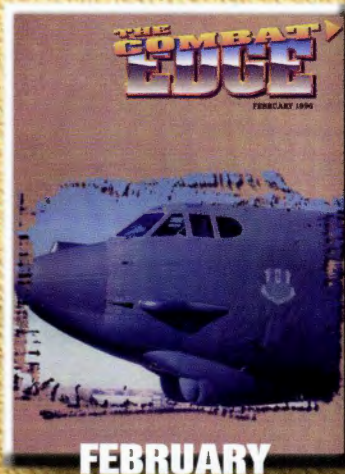
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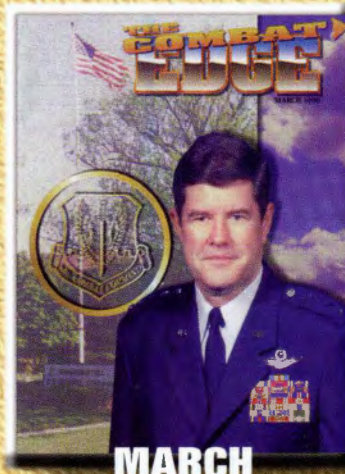
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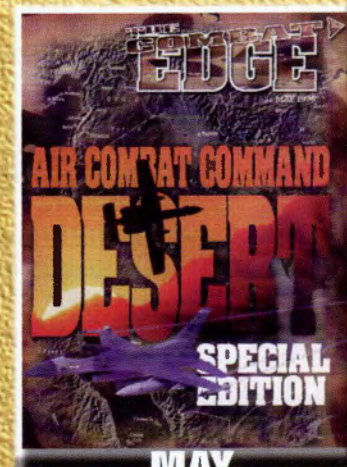
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Lt Col Jude Krejci - JUL 96

AIRCRAFT AND SUPPORTING MAINTENANCE PERSONNEL

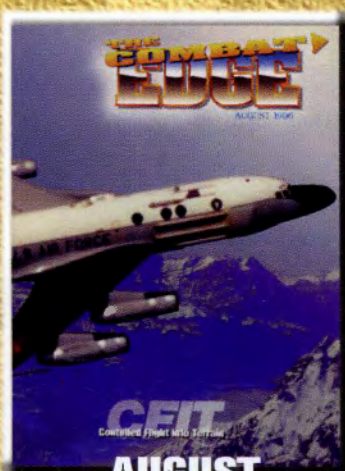
Composite Tool Kits
TSgt William L. Miller - JAN 96, FLT



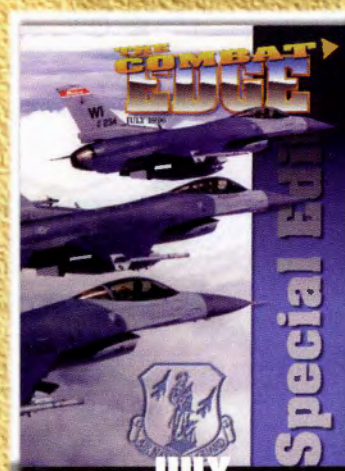
APRIL



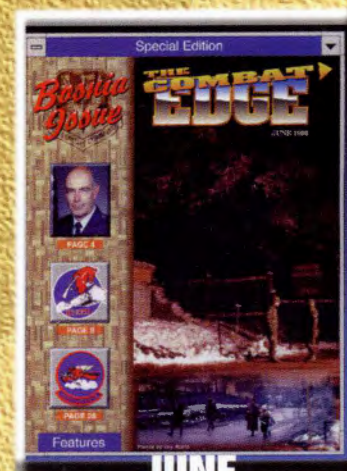
MAY



AUGUST



JULY



JUNE

ANY BOMBS IN YOUR CLOSET?

Hazards of unexploded ordnance
TSgt Rob Fuller - OCT 96, WPNS

ARGUS OVER 10: FLIGHT SAFETY AND THE BIG PICTURE

Situational awareness
Maj Jeff Alfier - JUN 96, FLT

AU REVOIR, ADIOS, AUF WIEDERSEHEN

Farewell to Sgt Mark Bailey (ACC/SEP)
Staff Artist for *The Combat Edge*
JUN 96

AVOIDING CONTROLLED FLIGHT INTO TERRAIN

Improving operations, training, education, and awareness
Capt Dave Carbaugh and Capt Skip Cooper - AUG 96, FLT

BACK TO SCHOOL SAFETY

Child safety
Mr. Michael Mehalko - SEP 96, GRND

BLOWUP

Risk management; decision making
Mr. Malcolm Gladwell - DEC 96

CARBON MONOXIDE POISONING RISK INCREASES WITH ADVENT OF COLD WEATHER

Precautions against carbon monoxide poisoning
Mr. John Chavez - NOV 96, GRND

CELLULAR PHONES HAVE NAUTICAL LIMITS

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Boat/U.S. - AUG 96, GRND

CENTER ART

F-117A Nighthawk
JAN 96

CENTER ART

F-15E (4th Fighter Wing, Seymour Johnson AFB NC)
MAR 96

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C-130H Hercules
Mr. Don Feight - APR 96

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Air National Guard - A World Class Organization
JUL 96

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OCT 96, GRND

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F-16 Fighting Falcon
Mr. Engle - NOV 96

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A-10 Thunderbolt II
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National Highway Traffic Safety Administration - MAR 96, GRND

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Safety in the AOR
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Complacency
Mr. Stan Hardison - JUL 96

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Controlled flight into terrain
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QUESTIONS OR COMMENTS
CONCERNING DATA ON THIS
PAGE SHOULD BE
ADDRESSED TO HQ ACC/SEF,
CAPT "E.T." MOORE
DSN: 574-7031

Accolades

	TOTAL			ACC			CANG			CAFR		
	NOV	THRU NOV		NOV	THRU NOV		NOV	THRU NOV		NOV	THRU NOV	
		FY97	FY96		FY97	FY96		FY97	FY96		FY97	FY96
CLASS A MISHAPS	3	3	3	0	0	1	2	2	0	1	1	0
AIRCREW FATALITIES	10	10	0	0	0	0	0	0	0	10	10	0
* IN THE ENVELOPE EJECTIONS	3/0	3/0	3/0	0	0	1/0	3/0	3/0	0	0	0	0
* OUT OF ENVELOPE EJECTIONS	0	0	0	0	0	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 96	0	1.1	0.8	0.6	0.9	1.2	1.0	0.9	1.0	1.4	2.1	2.0
	FY 97	0	0										
8 AF	FY 96	0	0	0	0	0	0	0	0	1.2	1.0	1.7	1.5
	FY 97	0	0										
9 AF	FY 96	0	0	0	0	0	1.1	1.0	0.8	0.8	2.1	1.9	1.8
	FY 97	0	0										
12 AF	FY 96	0	3.4	2.4	1.8	2.9	2.3	2.0	1.7	1.5	1.4	3.1	2.9
	FY 97	0	0										
DRU	FY 96	0	0	0	0	0	0	0	0	0	0	0	0
	FY 97	0	0										
CANG	FY 96	0	1.9	1.3	2.2	1.8	2.2	1.9	1.7	2.0	1.8	2.0	1.9
	FY 97	0	3.8										
CAFR	FY 96	0	0	0	0	0	0	0	0	0	0	0	0
	FY 97	0	6.3										
TOTAL	FY 96	0	1.3	0.9	1.0	1.1	1.4	1.2	1.0	1.2	1.1	1.9	1.8
	FY 97	0	1.9										
MONTH		OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP

(BASED ON PROGRAMED HOURS FLOWN)

WINTER DRIVING SAFETY TIPS



- ❄️ Check condition of windshield wipers
- ❄️ Replace worn tires and ensure your spare is in good condition
- ❄️ Check vehicle for proper fluid levels and appropriate concentration of antifreeze in radiator for cold weather driving
- ❄️ Have your battery, exhaust system, and brakes checked
- ❄️ Keep an ice scraper and snowbrush on hand to keep windows clean for good driving visibility
- ❄️ Use seat belts and child safety restraints at all times
- ❄️ Carry an emergency road hazard kit in the event of breakdown (*battery cables, flashlight, extra blankets, flares, engine drive belts*)
- ❄️ Drive slowly and cautiously in wet and icy road conditions
- ❄️ Know your limitations (*when you feel tired, stop and get some rest*)