

The Combat **EDGE**

April 2001



The Combat EDGE

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Air Combat Command's Mishap Prevention Magazine

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COL. GREGORY A. ALSTON, CHIEF OF SAFETY



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If you were wondering who authored "Staying Ahead of the Game!" in our March 01 issue, it was Lt. Col. Steven E. Bell, 12 AF Deputy Chief of Safety, Davis-Monthan AFB, Ariz. We apologize for the omission.

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APRIL FOOLS

April is upon us, kicked off by the infamous April Fool's Day. If you are not vigilant on April 1st, you may fall for an April Fool's prank from a friend — or ex-friend. If you are told some outlandish event has occurred, such as "The moon just escaped orbit and is blasting out to space!" and you bite with, "Wow! Let's turn on the news," then you will have been successfully fooled. Your only mistake will have been not maintaining awareness, but no real harm will have been done. While some April Fool's jokes are sure to be much more elaborate, staying alert will be the key to having a prank-free day. Risk awareness requires this same alertness 365 days a year. It is a daily, nonstop discipline.

April is a transition month. It is a time of moving from the rigors of winter to the dangers of spring and summer. It is important to be smart during this transition, and awareness is the key to being smart. Be aware that you need to prepare your mind, body and equipment before engaging in the upcoming outdoor activities and vacation road trips. Mentally, make a careful plan for your activity. Start with the ACC Personal Risk Management Guide (wwwmil.acc.af.mil/se/) for things to consider, such as preparation, hazards and risk mitigation. Physically, be sure you are in shape for hiking, climbing, biking, baseball, etc., and always wear the appropriate personal protective equipment. The equipment you use is equally important. Bikes should be tuned up; cars serviced for long trips; proper hiking boots worn; cell phones, first aid and snakebite kits packed. These reminders may seem like common sense, but the problem with common sense is that sometimes it is not so common.

It is not just an "April Fool" who is not aware of his or her surroundings; many people cut corners for convenience and assume unnecessary risk. It seems there are always a few of us who disregard obvious risk concerns due to lack of time or money or even because of routine irresponsible behavior. It does not have to be April for you to be considered foolish if you make it a regular practice to not wear a seat belt, helmet, life vest or other protective equipment. Your family, friends and unit members are counting on you to be there for them, so keep your guard up and avoid taking foolish risks in April or any other month.

Col. Greg "Vader" Alston
ACC Chief of Safety

*By Master Sgt. Anthony Stennis
Air Combat Command Superintendent of
Ground Safety Programs Analysis
Langley AFB, Va.*

Although it was 18 years ago, I can still remember the last time I saw my supervisor. My story begins at the end of 15 consecutive days of 13-hour shifts. Finally, the words everyone eagerly awaited to hear were transmitted over the security forces' radio, "Exercise, Exercise, Exercise. We have official termination of the base-wide exercise at 2135 hours." Fortunately for me, our flight had 2 days off before our regular work cycle started again. I, along with five other security forces flight members, decided to stop by the "All Ranks Club" and have a couple of drinks. When we saw how crowded it was, we quickly changed our minds. We decided to pick up some beer from the package store and gather at my apartment to play cards since I lived the closest to the base. We were really enjoying ourselves — slamming cards, laughing, telling jokes and drinking beer. My supervisor, whose wife was 6 months pregnant, decided it was time for him to go home after about 45 minutes. I remember how we all gave him a hard time about his driving skills because he backed out of the parking lot so slowly and then he drove off. Little did any of us know that night would be the last time we would ever see him. The remaining flight members departed soon after and then I went to bed.

About 2:30 a.m., I awoke to loud knocks at my door. It was my shift commander. He told me that my supervisor had been involved in a serious vehicle accident and had only a slight chance of survival. He asked me if I knew whether my supervisor had been drinking. I replied, "Yes." I had seen him drink at least two beers earlier that evening. He then asked whether my supervisor appeared drunk or disoriented to which I replied, "No." I had seen my supervisor drink much more on other occasions without any visible effects. Even though I was an A1C and my supervisor was a buck sergeant and the ranking person present, I was told that I was still accountable for the alcohol served at my apartment. The fact that six of us had purchased two six packs of beer had made it improbable to me that any one of

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us would have been in jeopardy of getting stopped for driving under the influence (DUI) or in too bad of shape to drive home. At least that is what I had thought prior to this nightmare I was experiencing.

That night turned out to be one of the worst nights of my life. I was questioned by agents from the Office of Special Investigations for about 4 hours and was threatened with disciplinary action. Apparently, my supervisor had left my apartment and cut through base on his way to his off-base residence. He did not have any problems on base; however, after he departed through the back gate, he lost control of his vehicle, struck a median and flipped 12 feet in the air striking a palm tree. The impact of the collision crushed the roof of the vehicle causing severe head trauma. He was placed on life support and did manage to live another day

alcohol+TOR



before succumbing to his injuries.

I was an emotional wreck. I blamed myself for his death and became more and more depressed. The toughest part of this ordeal was facing my supervisor's pregnant wife and looking into her eyes at the funeral. To see how devastated she was over the loss of her husband and knowing their unborn child would never know its father, was such a tremendous burden. It took me almost a year before I finally found closure; however, the lesson I learned from this experience will stay with me

for a lifetime.

People do not realize that just a little alcohol under the wrong circumstances can be devastating. Many DUI offenders have only had a few social drinks after work, some wine with dinner or a cocktail at a luncheon. They are not aware of how much they have impaired their ability to drive. This is especially true when there are other contributing factors that determine the effect alcohol may have on the body. These include the alcohol content of the drink, the number of drinks, total time taken to consume the drinks, use of medication, a person's weight, fatigue and the amount of food present in the stomach. I was aware of most of these factors at the time of this incident, but I always assumed the signs of impairment would be visible like slurred speech, staggering or mood swings. As with most assumptions, I was wrong.

Now that I am a Safety professional and have 19 years under my belt, I can look back and more clearly see some of the contributing factors that combined with alcohol to cause this tragedy. The biggest factor was fatigue. We had been working 13-hour shifts for 15 consecutive days. All of us were completely worn out. Another factor was judgment. My supervisor was traveling at an excessive speed and did not realize how much the beers he had consumed impaired his ability to control his vehicle.



This article will be my last contribution to *The Combat Edge* as a member of the ACC Safety staff. I am moving on to my next assignment at Mildenhall AB, United Kingdom. I just wanted to thank everyone for making my tour in ACC a memorable one.

Make no mistake; even a little alcohol, combined with the wrong factors behind the wheel of a car, can be deadly. It not only affects the person who does it, but in almost every case, it permanently scars those who are left to go on with their lives. The loss of life is traumatic no matter how it happens, but it seems doubly so when the circumstances were preventable. Take the warnings to not drink and drive seriously, even if you cannot see any of the classic alcohol-induced effects. There will always be other factors that will amplify the effects of alcohol and you may not be aware of them. Do not relive my story. Do not wait until someone you know dies to heed the warnings. The alcohol+ factor is real and it can kill. ■

What Happens to those SIB Recommendations?

*By Maj. Craig K. King
Air Combat Command Flight Safety
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Ever fly an Air Force aircraft? Ever work on one? Ever read the Final Message from a Safety Investigation Board (SIB) mishap report? You can skip this article if the answer is “no” to all those questions; otherwise, keep reading ...

If you are still with me, here is the deal: I have an additional duty that directly or indirectly affects you in a very personal way. I am the guy in Air Combat Command (ACC) who tracks to closure all the recommendations generated by SIBs to help us prevent future mishaps. I let the various staff agencies within ACC know which of those recommendations they are responsible for, and I brief the Commander of ACC (COMACC) semiannually to ensure he knows which SIB recommendations we are able to accomplish and to ensure his oversight when circumstances — usually lack of funding — prevent implementation. This function, which we call the Mishap Review Panel (MRP), is especially active in ACC because we are the “lead command” for so many Air Force aircraft. There are currently 261 open SIB recommendations in our data-

base.

How do we in the Air Force go about doing what I just described? This has recently been the focus of the Department of Defense Inspector General and the General Accounting Office. Both of these organizations are presently charged with trying to figure out how the different Services implement safety recommendations. The ACC Safety office is helping answer this question because we have historically — thanks to my predecessors and office mates — done a good job tracking the hundreds of recommendations generated by SIBs, implementing as many recommendations as possible and advising the Air Force Safety Center when we are unable to comply.

The timeline that follows is a little bit simplified, but sequentially shows most of the steps between the occurrence of a mishap and the resulting SIB recommendations that are eventually taken for action. I will step you through a representative sequence of events for a notional ACC Class A flight mishap. The timeline would be slightly different for another major command’s (MAJCOM’s) accident or for

a Class B mishap, but the end result would be the same. My hope is that you will be left with an understanding of how recommendations are analyzed and tracked and a warm fuzzy that the hard work accomplished by our safety boards is both appreciated and acted upon.

1) Day 1: Mishap occurs. ACC is notified. Interim Board forms at mishap location to begin investigation.

2) Approximately Day 2 through Day 30: A "permanent" SIB (usually about 10 members headed by an O-6 or higher) takes over the investigation from the Interim Board and writes an extensive "formal report."

3) Day 30 through Day 45: For 3 days in this timeframe, the SIB forms up at ACC headquarters and briefs the convening authority (in this case, COMACC) on their findings and recommendations. Upon COMACC's approval, ACC releases the Final Message and formal report to the field exactly as written by the SIB.

4) Ten days following approval: The Final Message is then scrutinized within ACC. Intense staff work takes place, starting at the action officer level (guy like me), through the various ACC echelons (including the mishap wing, numbered air force [NAF] and every affected ACC directorate) and subsequently to COMACC for approval. The "ACC Addendum" to the Final Message is approved and eventually sent in message format to the recipients of the SIB's original Final Message. This addendum is ACC's suggestion to the Air Force Safety Center on how we feel the SIB's wording should be refined to best prevent mishaps in the future.

5) Next 2 months: The Air Force Safety Center collects the previously mentioned messages and solicits "Comments and Indorsement" (C&I) from virtually anyone considered to be a stakeholder. The primary players are other MAJCOMs and those agencies tentatively assigned to implement specific recommendations.

6) Approximately 150 days after mishap: After considering the SIB's formal report, the convening authority's addendum, and C&I inputs from the various wings/NAFs/MAJCOMs and other staffing agencies, the Air Force Safety Center issues its Memorandum of Final Evaluation (MOFE). This is a message stating the official Air Force position on what

happened, what caused it and how the Air Force would like to keep it from happening again. The MOFE also identifies the Offices of Primary Responsibility (OPRs), which are those agencies charged by the Safety Center with taking the lead on implementing specific recommendations.

7) Semiannually: Each MAJCOM formally reviews every one of its open recommendations. Status on each is subsequently reported to the Air Force Safety Center, which maintains a database for the Air Force-at-large. That database is updated semiannually, available to each MAJCOM and reviewed prior to subsequent MRP cycles. This interaction ensures that neither the Safety Center nor the responsible MAJCOM inadvertently drops a recommendation "off the scope."

The process I described above is a good one, but it requires a lot of work on the part of many agencies. We presently coordinate with no less than 47 different organizations, both within and outside of ACC, in our quest to complete our assigned recommendations. You would be pleasantly surprised to see the vigor with which these people engage their taskings. In fact, many recommendations are implemented in full before the MOFE even hits the street. In addition to our 261 current open recommendations, ACC has closed over 800 recommendations since our inception in the early 1990s.

For the most part, "closing" a recommendation is simply a matter of telling the OPR what the recommendation is, getting an update when their work is complete, briefing it to COMACC and then advising the Air Force Safety Center. As you might imagine, it is not always that simple, and here is why. When conducting their investigations, SIBs are rightfully instructed to consider only the effect, in terms of mishap prevention, of their proposals — NOT the feasibility nor cost of implementation. That is OK because new technologies sometimes allow us to fix problems in a way not even imaginable when the SIB dreamed up the recommendation. On the other hand, there are cases where a recommendation sounds a lot easier or cheaper or more beneficial to the SIB than reality dictates.

In a resource-constrained environment, it is our job as lead MAJCOM to make the "hard call" on whether to accomplish each recom-

mendation in full, accomplish it in part, find an acceptable work-around or close it "without action." This last option is not taken lightly. It requires research, cost versus benefit analysis and COMACC approval. It is in the field of prioritizing recommendations that we are currently making great strides. Under the expert guidance of a recent new hire in our office, Capt John Schroeder, we have recently upgraded our tracking system to 21st century standards by employing a robust off-the-shelf database to assist tracking and staffing. This has simplified our mission of presenting a list of "problem" areas to COMACC and ensures four-star visibility on the right items — those that need a little "push" if they are to be adopted.

Along the same lines, we are also working with the Air Force Safety Center to apply operational risk management (ORM) to our MRP. Since each recommendation is, in essence, an attempt to mitigate risk by eliminating or working around a hazard, why not assign each "hazard" a risk value,

subtract out the "residual risk" left over after implementing the fix, divide that by the cost of implementing the recommendation, and then rack-and-stack by the resulting "mishap prevention value"? We are presently struggling with how to do that properly, as it is not as simple as it sounds. We are hopeful that we can use such a system internally to prioritize our own recommendations for ACC funding, while providing the Safety Center a numerical ranking of our problem areas. This information can then be used to garner support for extra dollars when ACC cannot afford to finance a fix on its own.

Obviously, neither ACC nor the Air Force has the resources to fund every single recommendation submitted by SIBs. Most are desirable, but some are just not feasible. The good news is that we can and do implement the vast majority of SIBs' ideas. The challenge is in determining which recommen-

dations are feasible and which are not, and this is a job we take very seriously. We recognize that every recommendation was paid for in advance by damage to our prized equipment or, even worse, injury or the loss of one of our fellow airmen. Every recommendation is initially treated with the same level of respect and effort. It is essential that we extract all the mishap prevention value possible from every report. You will continue to see the results of our efforts in

the field: time-compliance technical orders (TCTOs), flight crew information files (FCIFs), new aircraft modifications, syllabus adjustments, etc. We will do whatever it takes to prevent the next accident. The MRP gives us a mechanism to keep good ideas on the front burner for months or even years until they are either completed or proven unworkable by any reasonable standard — and only then with COMACC oversight.

Now you are armed with the knowledge of how we manage the hundreds of SIB recommendations that are authored to save our lives and our airplanes. Of all the things we do in ACC Flight Safety, the MRP is the most tangible evidence of rubber meeting the road. If you are ever called upon to participate in a SIB, be assured that your ideas will be treated with due respect from start to finish. Through the MRP and with the help of innumerable professionals who work diligently to investigate mishaps and implement solutions, we turn the lessons learned from unfortunate circumstances into positive action to prevent similar mishaps in the foreseeable future.




If you need more details on how this aspect of mishap prevention actually works, please do not hesitate to contact me (craig.king@langley.af.mil) or Capt John Schroeder (john.schroeder@langley.af.mil) here in the ACC Flight Safety shop. ■

In a resource-constrained environment, it is our job as lead MAJCOM to make the "hard call" on whether to accomplish each recommendation in full, accomplish it in part, find an acceptable work-around or close it "without action."

Weapons Safety

ACC Losses for FY 01

(1 Oct 00 - 31 Mar 01)

Number of Weapons Mishaps / Dollar Losses*			
	Class A	Class B	Class C
8 AF	None	None	None
9 AF	None	None	None
12 AF	None	None	None
AWFC	None	** 	None
TOTAL	None	1/\$279K	None
Weapons Fatalities - None Nuclear Mishaps - None		* Cost of most recent mishap(s) not yet available  = Missile Mishap  = Explosive Mishap	
(**) FOT&E: FOLLOW ON TESTING AND EVALUATION			

As weapons safety managers (WSMs), we are frequently required to inform our leadership of changes to the explosives safety guidance in Air Force Manual (AFMAN) 91-201, *Explosives Safety Standard*, and the resulting impact. This experience can be a daunting one depending on the magnitude of the impact. I recently talked to a WSM who described how he was placed in the hot seat early in his career trying to explain one of those changes, which had big implications for his wing. His story follows:

"I had just returned to my home base from a trip and was settling back into my daily routine when I was surprised to discover that a change had been made to AFMAN 91-201. I began the arduous task of reviewing the change because I was curious to see how it might affect operations at my base. I soon discovered that the change added the criteria for parking combat aircraft in excruciating detail. No longer would I have to calculate net explosives weights (NEW) or apply cubed root formulas. All of that had already been done in this change and there it was right before my eyes. The criteria included standard configuration loads, the totaled NEW and the required distance between aircraft. This change would save a lot of time, but there was a problem ... the new criteria increased the distance required between combat aircraft parked at my base. WOW! The implications for my base would be immense. Hundreds of thousands of dollars would have to be spent re-painting taxi lines and adding an additional parking apron.

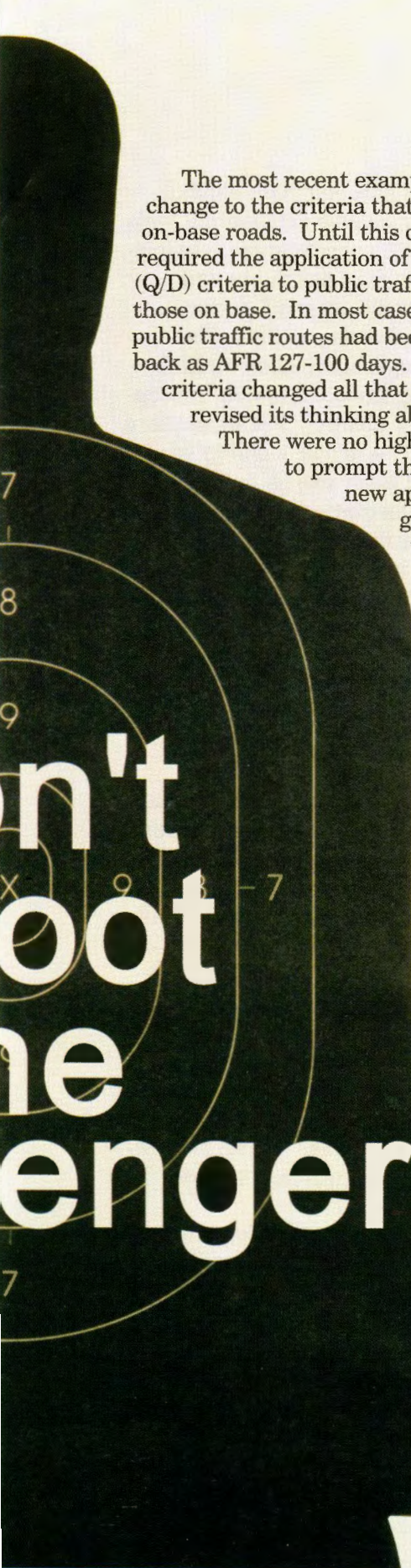
"As I thought about the best way to approach my leadership with this issue, I realized that we were having an operational readiness inspection in 3 days. This increased my urgency. The leadership needed to know right away what impact this new guidance would have if we were going to practice the same way we will have to fight. Even though I did not fully understand the new guidance or the reasons why it had changed, I was the WSM and it was incumbent upon me to inform key players of the change. After several phone calls and conversations with functional managers and my chief of safety, I found myself between the operations group commander and the wing commander. After carefully pointing out the change in the AFMAN and explaining what I thought the base would need to do in order to comply, I knew I was not the most popular person in the room. The atmosphere was even tenser because I was ill prepared to address the reasons for this AFMAN

change. As a result, I was not very effective in promoting compliance with the new guidance and it seemed like things went downhill from there."

This WSM's experience illustrates well the point I would like to make. In the weapons safety arena, many of us, whether we are a shop chief, functional manager, commander or the WSM, will find ourselves trying to understand or explain changes in explosives safety guidance so our leadership can make decisions about implementation. It can be very difficult to be a messenger of this kind of information, but it is an important job and one that can literally save lives.

In the 5 years I have been in weapons safety, I have seen five different AFMAN 91-201 standards published. A sixth is currently in the works. New guidance like this routinely flows down from the Department of Defense Explosives Safety Board (DDESB) and is incorporated into the AFMAN 91-201 through a rewrite or interim change. While the documentation has no problem getting out to the units, the rationale for making a change often does. This is because the reasons are frequently based on highly technical reports from explosives testing or other methodology. This creates a situation where changes to criteria are not always fully understood, even by those who have to champion the changes to others.

Don't Shoot the Messenger



Don't shoot the messenger

The most recent example of this is a change to the criteria that will be applied to on-base roads. Until this change, the AFMAN required the application of quantity distance (Q/D) criteria to public traffic routes except for those on base. In most cases, the on-base public traffic routes had been exempted as far back as AFR 127-100 days. This new AFMAN criteria changed all that because the DDESB revised its thinking about this issue.

There were no highly technical reports to prompt this change — just a new approach to Q/D

guidelines. Whatever the rationale, the result will be the same at the base level. Q/D criteria will have to be applied to most on-base roads. It will be the local WSM who will have to promote these additional requirements to the base leadership and, more than likely, without having the rest of the story. There have been other changes that have had similar reverberations throughout the Air Force like the change to the hazard class division 1.2 criteria. Now thousands of explosives site plans will have to be re-accomplished across the Air Force. While changes like this one can have major consequences, it would only

be fair to mention that there are other changes that have made the jobs of maintainers and operators easier and required minimal implementation. Everyone applauded when the DDESB recently reduced the minimum fragment criteria of the CBU-87 from 1400 feet to 1250 feet. This increases storage parameters and the number of aircraft that can be loaded in a given area.

Whatever the end result of a change might be, the messenger of that information is the same — the WSM. A lot of WSMs have limited experience in safety and even less experience with the DDESB, explosives testing and methodology. This can be a handicap when trying to explain the rationale behind DDESB decisions. But no matter how difficult or widespread implications of the message might be, the WSMs understand how important this part of their job is. They also understand that it is our human nature that demands to know why something has changed or why a rule exists in the first place. This is especially true when it impacts local operations. While the absence of a reason does not decrease the importance of the change or the fact that the DoD and Air Force have approved it, it might help to know that those of us at the MAJCOM are a little closer to the decision makers and often have access to the rest of the story. We encourage each of you to contact us if you find yourself in a similar situation. We may be able to answer some of those “why” questions that will make everyone a little more confident about making the required changes.

The WSM at the beginning of this article did get off to a rocky start, but here is the rest of his story. After many last minute meetings and PowerPoint presentations on how best to conduct safe operations within AFMAN guidelines, the local mission went ahead without any weapons safety glitches. This shows how critical it is for functional experts and WSMs to work together to understand and ultimately apply new explosives safety criteria. It also shows that although the WSM may sometimes seem to be the bearer of bad news, don't shoot — he or she is actually a guardian angel in disguise. ■

*By Senior Master Sgt. Aaron S. Solomon
Air Combat Command Superintendent of
Weapons Safety
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DUI Trends

DUI Trends

The relationship between alcohol and motor vehicle accidents is well documented. Alcohol consumption is associated with a wide range of accidents and injuries resulting from impaired performance of mental and motor skills. The skills necessary to operate a motor vehicle are complex making them extremely susceptible to the effects of alcohol. For example, a 0.02 BAC can impair a driver's ability to divide attention between two or more sources of visual information; steering ability may be impaired with a BAC as low as 0.035; judgment is impaired at 0.04; consistent impairment occurs in eye movements, glare resistance, visual perception, reaction time and information processing at 0.05; and significant reaction time loss occurs at 0.07. All these impairments occur below the 0.08 national standard recently passed by Congress in an effort to combat a lingering problem in the U.S. — drinking and driving.

There were 15,786 alcohol-related traffic fatalities in the U.S. last year. These represent 38% of the total traffic fatalities for the year. The National Highway Traffic Safety Administration (NHTSA) estimates an additional 308,000 people were injured in crashes where alcohol was involved. That is one injury approximately every 2 minutes. Furthermore, NHTSA estimates one in every three Americans will be involved in an alcohol-related crash at some point in their lives. When reviewing the data, several significant trends stand out.

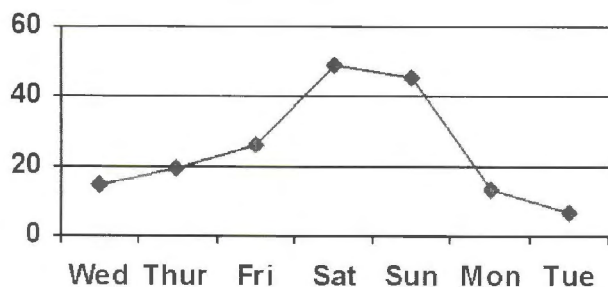
Thirty percent of traffic fatalities occurred in crashes in which at least one driver or non-occupant had a BAC of at least 0.10 and 70% of the 12,321 people who died in these crashes were intoxicated themselves. The remaining 30% were passengers, non-intoxicated drivers, or non-intoxicated non-occupants. The rate of alcohol involvement in fatal crashes was more than three times higher at night compared to daytime. This increases to five times if non-fatal crashes

are included. For the days of the week, 51% of fatal crashes on the weekends were alcohol related compared to 29% on weekdays. The age group with the largest intoxication rate was the 21 to 24-year-olds, followed by 25 to 34-year-olds, and then 35 to 44-year-olds.

Just over a year ago, 12th Air Force declared war on drinking and driving by initiating several programs to combat the problem. As part of the program, our units report instances of drinking and driving by assigned people to the 12 AF commander. These reports are tracked and then trended to provide information to combat the problem. During FY 00, 174 people assigned to 12 AF installations and units were stopped for suspected DUI. One might not consider this a large number considering the total number of people assigned to our installations, but they could just have easily been fatalities. The information that follows is not restricted to fatalities, but it does show some common trends with them. Additionally, these numbers represent only 12 AF statistics, but we believe they would be a good estimate of the ACC-wide statistics.

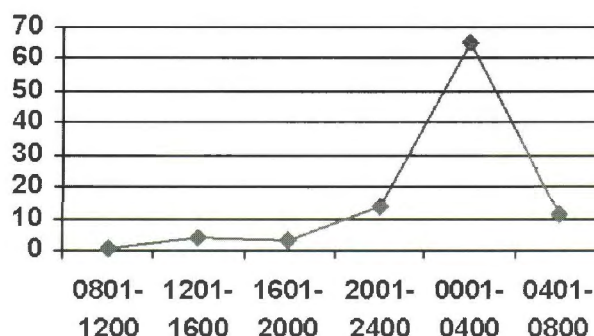
As one might expect, the weekend leads the way for DUIs. Collectively, Friday, Saturday, and Sunday account for 69% of our DUIs. When broken down by day, Saturday leads closely followed by Sunday. Friday is a somewhat distant third. Monday and Tuesday have the lowest total and on Wednesday the numbers begin to increase. This trend might be explained by a combination of increased consumption and enforcement activities.

DAY OF THE WEEK



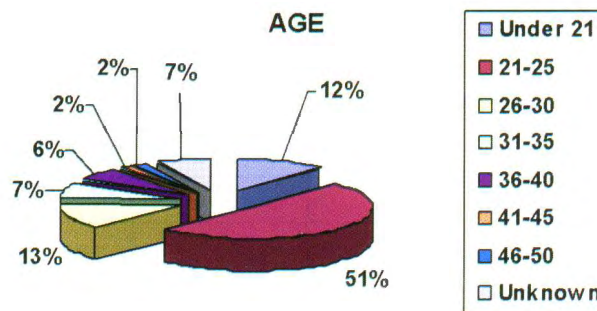
As far as time of day goes, nighttime far exceeds daytime in the number of DUIs. The numbers are fairly consistent from 0801 to 2000 then begin to rise from 2001 to 2400. They peak from 0001 to 0400.

TIME OF DAY



When it comes to age, our young people are the highest at-risk population, particularly 21 to 25-year-olds. They accounted for just over half of our DUIs. Combined, the three youngest age groups accounted for three quarters of our DUIs. A possible reason might be their inexperience with alcohol. For instance, they might exhibit more symptoms of intoxication even though they consumed the same amount of alcohol as the other groups, giving way to probable cause. Younger people tend to be bigger risk takers as a group too. Or, they may simply drink more than the other groups before getting behind the wheel. In any case, they

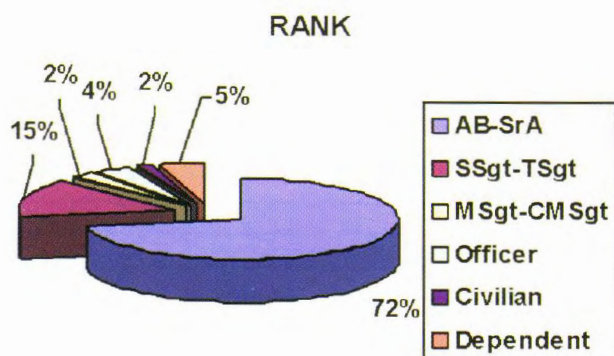
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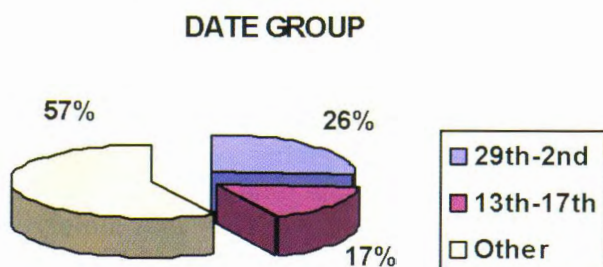
are our largest risk group.

Since the youngest year groups account for the largest number of DUIs, it stands to reason the rank structure would follow suit. It does. People in the ranks of AB to SrA

accounted for almost three quarters of our DUIs. Of these, A1Cs account for over half of them.



One of the statistics not included in the national fatality statistics are dates. In 12 AF the 29th to 2nd and 13th to 17th accounted for almost half our DUIs, but these days only account for a third of the days in a month. This is not really a surprise as military paydays fall within these timeframes. As far as the actual days, the first day of the month had the most DUIs, closely followed by the 17th.



Statistically, our DUI profile says you are high risk if you are a male (they accounted for 87% of our DUIs), 21 to 25-years-old, in the rank of AB to SrA. If this group is on the road, it is probably on a weekend, between 0001 and 0400 hours, on or near the payday associated with the first of the month and your BAC will be in the 0.08 to 0.15 range.

Nationally, the most common reason given for driving while impaired is "I thought I was OK to drive." I imagine most of our people stopped for DUI would say much the same thing. Unfortunately, it is just not true. Although symptoms may vary from person to person, alcohol impairs one's ability to operate a motor vehicle safely. The chances of being involved in an accident are 11 times higher for drivers with a BAC between 0.05 and 0.09. With a BAC of 0.10, the chance is 48 times higher. With a BAC of 0.15, the chance is an estimated 380 times higher. Furthermore, alcohol impairs the good judgment necessary to decide if one should operate a vehicle after drinking. Therefore, the decision to find an alternative way home after drinking must begin before drinking. The life you save could be yours, a coworker's or that of a family member. ■

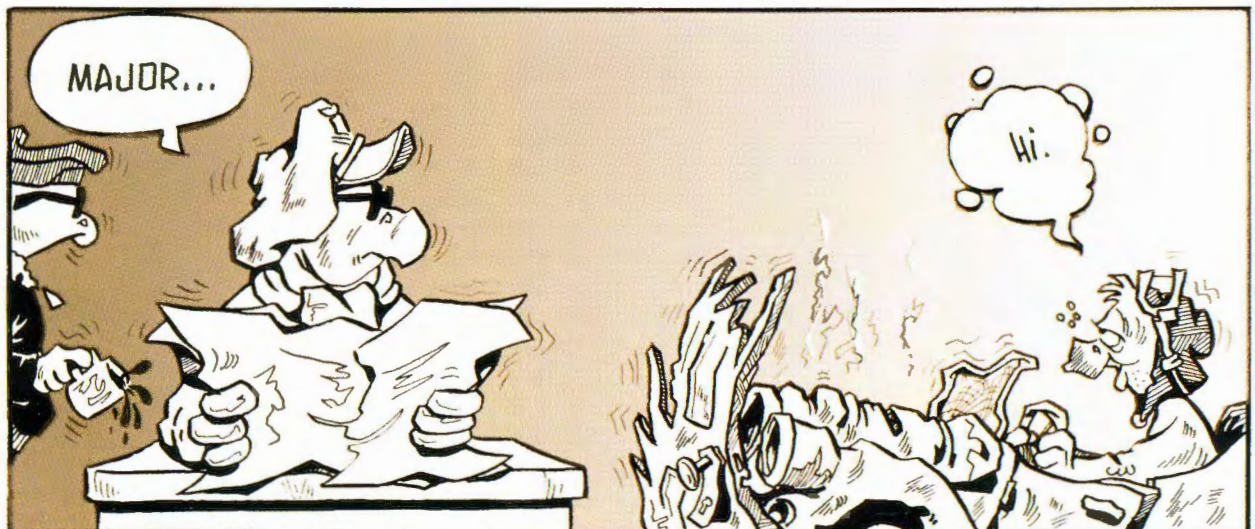
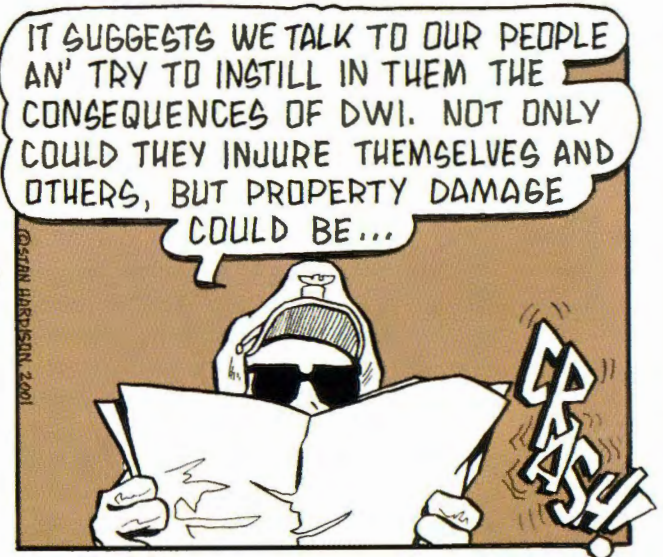
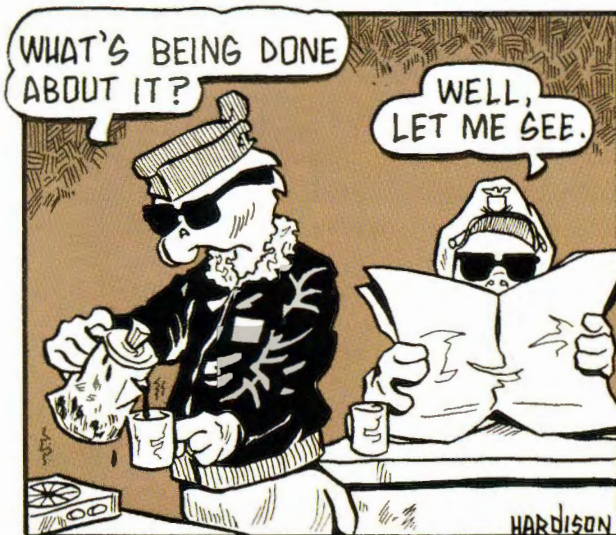
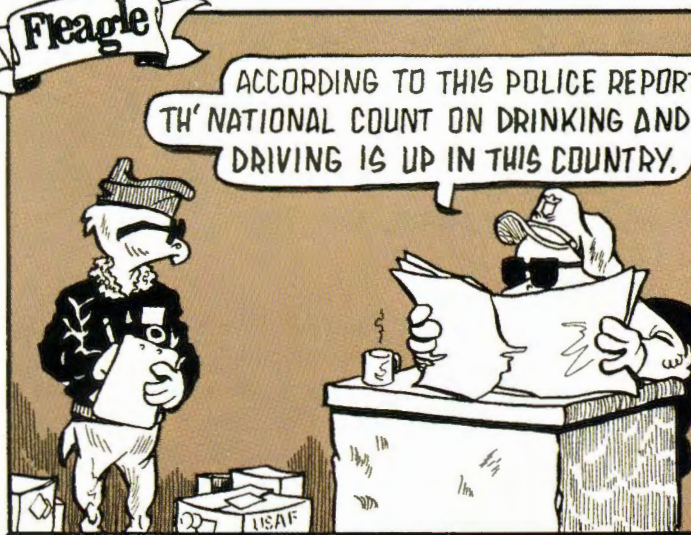
*By Tech. Sgt. Michael Orr
12th Air Force Ground Safety NCOIC
Davis-Monthan AFB, Ariz.*

DRINKS NEEDED TO EXCEED OR REACH LEGAL LIMIT

Male (180 lbs)					Female (180 lbs)				
Drink	BAC level (2 drinks/hour)				Drink	BAC level (2 drinks/hour)			
	1hr	2hrs	3hrs	4hrs		1hr	2hrs	3hrs	4hrs
Beer (12 oz; 6%)	.04	.08	.12	.17	Beer (12 oz; 6%)	.08	.15	.23	.31
Wine (8 oz; 10%)	.05	.10	.15	.19	Wine (8 oz; 10%)	.09	.17	.26	.35
Liquor (1 oz; 96pf)	.06	.12	.19	.25	Liquor (1 oz; 96pf)	.11	.22	.33	.43

NOTE: These numbers are provided for reference to the legal limit only. Each individual metabolizes alcohol differently. Additionally, any alcohol in the blood system affects one's ability to operate a motor vehicle.

Fleagle



MONTHLY AWARDS

PILOT SAFETY AWARD OF DISTINCTION

*Capt. Sean M. Carpenter
78th Fighter Squadron, 20th Fighter Wing
Shaw AFB, S.C.*



Capt. Carpenter demonstrated superior airmanship as number two in a four-ship of F-16CJs participating in a Green Flag composite force exercise on the ranges north of Nellis AFB, Nev. Each aircraft in the strike package was carrying four canisters of live CBU-87 cluster bombs. Following a low-level ingress, Capt. Carpenter's flight executed sequential low altitude toss weapons deliveries. When Capt. Carpenter attempted to release his munitions at approximately 2,500 feet above ground level, his aircraft began a rapid, uncommanded rolling movement to the right. Reacting quickly, he immediately countered the roll with full left side-stick controller input and transmitted a "Knock-it-Off" call. Capt. Carpenter visually confirmed that two CBU-87 munitions canisters on the right wing had not released causing the rolling movement. Assessing the 2000-pound weight imbalance, he began a climb and slowed the aircraft to reduce the stick forces required to maintain aircraft control. He determined he could maintain safe aircraft control for a re-attack. After clearing and reloading the stores management system in an attempt to reset the system and verifying proper operation, Capt. Carpenter was still unable to release the munitions during the re-attack attempt. He then conferred with his flight lead and Green Flag range control and decided to attempt to jettison the munitions using the F-16's selective jettison mode, but was unsuccessful. As a final option, he jettisoned the CBU-87 canisters along with the aircraft's triple ejector rack mounting equipment and safely recovered his aircraft to Nellis AFB. His quick reaction, composure under pressure, flying skill and superior airmanship assured the safe recovery of his aircraft, as well as the safe disposal of 2,000 pounds of hung live munitions.

CREW CHIEF SAFETY AWARD OF DISTINCTION

*Staff Sgts. Barry R. Williams and Bryan L. Jones
33rd Operations Group, 33rd Fighter Wing
Eglin AFB, Fla.*



On 18 Nov 00, while TDY to Lake City, Fla., for the annual Lake City air show, Sgts. Williams and Jones were completing pre-show checklists for the F-15 demonstration later that afternoon. A Russian-built SU-31 operated by the Sanford Aerobatic Team was set up approximately 50 yards across the parking ramp from the F-15s. Sgt. Jones observed one of the Sanford pilots attempting an engine start in preparation for his flying routine. Immediately upon engine start, flames began shooting out of the engine cowling. Since there was no fire bottle present by the SU-31, Sgts. Jones and Williams grabbed the 150-pound Halon bottle located next to their F-15 and ran with it in tow



across the ramp. Upon reaching the burning engine, Sgt. Williams extinguished the fire while Sgt. Jones assisted the pilot out of the aircraft preventing the loss of a civilian aircraft and possible loss of life.

AIRCREW SAFETY AWARD OF DISTINCTION

*Cpts. Richard E. Fields, John H. Van Huffel and Gregory K. Cyrus
Tech. Sgt. Robert W. Haas and Staff Sgt. Michael D. Howe
43rd Electronic Combat Squadron, 355th Wing
Davis-Monthan AFB, Ariz.*

After flying approximately two and a half hours of a night proficiency sortie, the crew of BATT 46 was practicing instrument approaches into Point Mugu Naval Air Station, Calif. Climbing out from a touch-and-go landing, and less than 100 feet above the runway, the aircraft commander (AC) noticed a strong yawing movement and immediately notified the crew. The flight engineer (FE) quickly recognized a severe over-speed of 106% RPM for the number three engine and immediately recommended shutdown. The AC ordered the shutdown and the co-pilot (CP) raised the gear. The navigator assisted the CP with the radios and declared an emergency with the tower controller. He coordinated clearance to turn to crosswind and then downwind. The AC commanded flaps up and the CP ran the "after takeoff touch-and-go" checklist. The airborne maintenance technician (AMT) alerted the crew that the number three engine was still rotating so the FE immediately reset the fire handle for it. This restored oil pressure to the propeller gearbox and mitigated the danger of explosion from mechanical friction that occurs when a rotating propeller does not get lubrication. The CP ran the "propeller fails to feather" checklist as the navigator coordinated a turn to final approach. The AMT noted the propeller had still not feathered, and the crew discussed the aerodynamic implications of this malfunction. The AC turned the aircraft to final and initiated flaps to 50% and gear down. The CP ran the "before landing touch-and-go" checklist and the navigator received landing clearance. The crew discussed whether anything had been overlooked and went over their operational risk management considerations for landing with an engine shutdown. The AC recovered the aircraft uneventfully and taxied clear of the active runway. Quick thinking, calm reactions and attention to detail by the crew of BATT 46 saved the lives of five aircrew members and countless civilians in the heavily populated town of Oxnard, Calif., as well as their aircraft, a \$37M high value airborne asset critical to the defense of this nation.

FLIGHT LINE SAFETY AWARD OF DISTINCTION

*Senior Airman Nathan D. Wells and Airman 1st Class Jarett K. Vasconcellos
522nd Fighter Squadron, 27th Fighter Wing
Cannon AFB, N.M.*



While performing de-arm operations on recovering aircraft flying in support of Operation NORTH-ERN WATCH, Airmen Wells and Vasconcellos noticed smoke coming from the left wheel of an F-16C which was fully loaded with six live missiles and taxiing into the de-arm area. As the pilot applied the brakes while exiting the runway, the left main wheel brake inner rotor failed and shattered brake pistons sprayed hydraulic fluid onto the brake stack causing the left main wheel to erupt into flames. Airman Wells directed the pilot to park the aircraft into the wind, eliminating the danger posed to several other aircraft carrying live munitions in the de-arm area. Meanwhile, Airman



Vasconcellos ran 65 yards to the nearest fire extinguisher and pulled it back to the crippled aircraft. After determining the safest approach to the aircraft, he entered the potentially explosive hazard area and expertly manned the fire suppression equipment, extinguishing the rapidly spreading flames. While the fire was being contained, Airman Wells directed the pilot to shut down the engine and evacuate the aircraft. The quick and decisive actions of Airmen Wells and Vasconcellos prevented catastrophic damage to a critical asset and possible loss of life and enabled squadron maintainers to diagnose and repair the aircraft in minimum time, returning the aircraft to the flying schedule the very next day.

GROUND SAFETY AWARD OF DISTINCTION

*Senior Airman Jason W. Grimes
1st Equipment Maintenance Squadron, 1st Fighter Wing
Langley AFB, Va.*



At approximately 7:05 a.m. on 22 Nov 00, Airman Grimes had just finished the daily inspection on a special purpose vehicle assigned to the munitions flight when he heard a buzzing sound. He looked around and followed the sound up to the top of an electrical pole located near the corner of a building. He identified a bright blue and white light coming from one of the breakers above the transformers. The electrical arc was unstable and intensified in loudness and brightness. Without delay, he called munitions control on the hotline and reported his finding to Staff Sgt. Anthony who immediately called the fire department and the civil engineers (CE) electrical shop, informing both of the electrical hazard. Airman Grimes returned to the electrical hazard to monitor it until CE arrived. Once the emergency team arrived on the scene, they immediately assessed the situation as dangerous, turned off power to the circuit and replaced two damaged circuit breakers. These electrical lines were connected to an explosive maintenance facility. The swift actions of Airman Grimes possibly prevented an explosive catastrophe. The munitions storage areas also rely on electricity for intrusion detection systems and security lighting, which could have been jeopardized if Airman Grimes had not acted with urgency. Airman Grimes' keen sense of awareness prevented this incident from escalating into a serious situation, which could have resulted in severe damage to valuable Air Force resources or possible loss of life.

WEAPONS SAFETY AWARD OF DISTINCTION

*Staff Sgt. Mark M. Tomas
Senior Airmen Scott A. Myllo and Kristopher Clepper
358th Fighter Squadron, 355th Wing
Davis-Monthan AFB, Ariz.*



Sgt. Tomas and Airmen Myllo and Clepper were members of the weapons maintenance crew that discovered and identified a defective gearbox bearing on the hydraulic drive assembly of the 30mm GAU-8/A gun, during an end-of-firing inspection of an aircraft. Their quick response in removing and replacing this vital component allowed the aircraft to be rapidly returned to mission-capable status without missing its next scheduled sortie. This maintenance crew's initiative did not stop there. They notified the armament flight of their findings and requested a non-destructive inspection of the gearbox housing where the bearing was installed. The results revealed a small crack on the gearbox housing that caused the bearing to wear unevenly. Their technical expertise and keen attention to detail avoided a catastrophic internal failure of the gun system and saved over \$100,000 in assets. These weapons maintenance crewmembers are dedicated to quality maintenance and consistently excel at doing the job right the first time. They are constantly looking for ways to improve weapons maintenance, personnel and training. In order to tackle the tremendous training backlog for new airmen, they have streamlined a training plan to familiarize 3-levels on the GAU-8 gun system, munitions bomb racks and other weapons hardware. Their tremendous efforts have contributed to the 355th Wing's rating as the "Best Wing in ACC" by the FY00 Logistics and Operations Consulting and Assistance Team. They are true weapons maintenance professionals who utilize all aspects of operational risk management in the course of their daily operations.

UNIT SAFETY AWARD OF DISTINCTION

*Combat Arms Section
355th Security Forces Squadron, 355th Wing
Davis-Monthan AFB, Ariz.*

The 355th Security Forces Squadron (SFS) Combat Arms (CA) Section provided instruction to over 1,100 355th Wing and 12th Air Force personnel in safe weapons handling and employment. CA scheduled and conducted training on the M16 and M16A2 rifles, M9 pistol, M203 grenade launcher, M870 shotgun and M60 machine gun. Over 100,000 rounds were fired down range with "zero" mishaps. This resulted in highly qualified troops being ready for immediate worldwide deployment, which ensured Davis-Monthan AFB was Aerospace Expeditionary Force-ready. CA had a 97% qualification rate that exceeded ACC's 90% average. In addition, the CA section also worked 30 off-duty hours to schedule and provide firearms support for the U.S. Navy Reserves. Fifty U.S. Navy Reserve personnel received academic and live-fire instruction on the M16 rifle and M9 pistol, which has enhanced inter-service relations. Despite 60% manning, the CA section responded to a SOUTHCOM requirement to modify 40 M16 rifles to M16A2 rifles in support of the U.S. counterdrug operations. The weapons were modified, inspected and processed for deployment in only 3 days exceeding 12 AF's timeline. CA also coordinated firing range use for the U.S. Border Patrol, Immigration and Naturalization Service, U.S. Customs, and local state and city police departments. Over 350 personnel from 12 federal, state and city agencies fired with "zero" mishaps. CA ensured every precaution was taken in the name of safety. The agencies gave highly favorable comments on the "professional and safe environment" provided by the CA section. This cooperation continues to build lasting relations with our local community. Section personnel were also selected as marksmanship coaches for the Boy Scout's Camp Lawton on Mount Lemmon where they instructed over 250 cadets on safe weapons handling and shooting fundamentals. All scouts received Merit badges. The section coordinated a target project for a \$275,000 firing range upgrade. The new and improved target lines ensure safety and course of fire compliance. Recognized as subject matter experts in firing range design and use, the CA section was asked to provide assistance in the design of an off-base range. The section identified potential risks of loss of life and damage to base facilities if the project continued. The section encouraged Pima County officials to insist on the installation of firing range baffles for 100% containment of direct rounds fired. This life-saving detection will ensure the safety of base and local community personnel. The CA section also identified a safety requirement modification plan for base firing ranges to ensure containment of rounds fired by U.S. Air Force (USAF) weapons. This was prompted by a proposal from Pima County officials and base Civil Engineers to construct a sewage treatment plant in the northeast quadrant of the firing range impact area. The CA section pursued and acquired a cost-free site survey from the Action Target Range Company for overhead baffles on all base ranges. This also included a bullet containment system or "total containment trap." This proposed project will ensure 100% containment of rounds fired, provide environmental solution for lead disposal and exceed ACC Commander firing range initiative program expectations and requirements. The section spearheaded the unit's annual weapon and ground safety inspection. CA quickly identified and corrected minor discrepancies resulting in the unit being one of the only two units in the 355 WG to receive an overall "Excellent" rating. The CA section prides itself on strict adherence to policy and established procedures. Comprehensive on-the-job training plans were implemented ensuring personnel practiced safety daily. Despite 60% manning, CA has not experienced unfortunate accidental discharges. Safe equipment and tool operating procedures were implemented ensuring 100% compliance with USAF technical orders and Air Force Occupational Safety and Health directives when performing weapon repairs and range maintenance. The CA section is a 101 critical days success story conducting weekly safety briefings, safety awareness training and seat belt usage spot inspections of students. The result has been no missed days, no injuries and no completed ACC Forms 164, *Ground Mishap Reports*. The safety initiatives and weapon safety briefings given on a constant basis have reduced personnel mishaps to zero.

Aircraft Mishap

Today's Air Force is one that is on the go, continuously being tasked to deploy to just about every region in the world. Although many of you know too well about worldwide deployments, there are a select few in the flying community that have an additional TDY burden to carry. These are our trained aircraft mishap investigators. An investigator probably knows better than anyone else that with the increased flying commitment we have, one thing is for sure — some type of aircraft mishap will occur. As an investigator and potential Safety Investigation Board (SIB) member, you cannot predict when and where the next aircraft mishap will occur; however, you should always be prepared to leave on a moment's notice.

Part of your preparation was completed when you graduated from either the Aircraft Mishap Investigation Course or the Flight Safety Officer Course. No matter which course you attended, you received the best training the Air Force has to offer on how to investigate an aircraft mishap. Sometimes you may not know the name of a part right away, but you can identify this widget from another and you even know when a thing-a-majig is out of place. You amaze your coworkers when you and your other SIB members figure out the what, when, where and why of an aircraft mishap. The one thing that puzzles everyone is how can someone be so smart, but still forget things that they will need while at the mishap location.

I know you are thinking to yourself, "Who is this guy to think that I am not prepared?" Well, being a Flight Safety NCO in a wing nearly 4 years, having conducted the yearly training for my potential SIB members and being a member on several Class A and B boards, I have heard and seen a lot. Believe me when I say that the majority of you are not prepared to leave on a moment's notice. My intention is not to slam-dunk anyone. Rather, it is to prepare you for that zero dark thirty phone call that officially makes you part of a SIB.

Remember what I said in my opening paragraph. Are you ready to go to "every region in the world?" Think about it. Anywhere means drastic climate changes, desolate remote areas and, in some cases, areas not suitable to live in. I

can speak with first-hand knowledge when it comes to weather. Last January, I received a call at 3:30 p.m. on a Friday informing me of an aircraft mishap in Iceland. I was tagged as the maintenance member for the SIB. Lucky for me, I had a lot of cold weather gear that I had accumulated over the years of working on the flight line. I found myself in some of the coldest weather that I have ever been exposed to. Temperatures never went above 10 degrees and wind chills reached as low as 45 degrees below zero. These conditions are hard to imagine when you live in a climate that rarely dips below freezing. Everyone struggles with relating to weather that is different from his or her immediate area. No one likes to think about the rainy, damp, desert or cold regions that we fly in, but those of us in the investigator business must. Now is the time to inventory all of your gear and make sure you have the appropriate clothing to protect you in any climate. If you need cold or hot weather gear or even a rain poncho, contact your unit resource advisor to have it issued to you. The weekend or holiday is not the time to realize that you are missing something.

Probably the biggest thing that everyone forgets is protective equipment. If I had a dollar for every time I heard one of my investigators say, "I forgot my leather gloves," I would be a millionaire. Flight gloves just will not work when you are handling jagged sharp pieces of metal. I knew one investigator who found out the hard way. He returned from a mishap with seven stitches in his hand because he had used



Investigators



...Are You Prepared?

By Master Sgt. Thomas E. Lyman, Air Combat Command Flight Safety NCO, Langley AFB, Va.

his flight gloves. There are many other pieces of protective equipment you should have besides gloves. Think about what you are going to be doing and what you may be handling and prepare properly. Remember, you are going to investigate a mishap, not to be one.

Also do not forget your hygiene products. I know what you are thinking ... if you forget something you can buy it. Granted, most mishaps occur around military installations, but what about that one time you are stuck in the middle of nowhere? Several SIBs have found themselves in a tent in the middle of the woods for days before moving back to civilization. You do not need to return home with a new call sign that you would rather not have.

The last thing that some people think about is, "Who will take care of the house, the kids, the dog and the bills?" Have you made arrangements in advance with a neighbor or

good friend to take care of these areas if you are ever tasked to leave on short notice? Some of you have a spouse or significant other that will handle this; others need to think about it. Is there anything that you may need a power of attorney for? You may want to get it early. There probably is not anything worse than trying to find someone at the last minute to take care of these things for you. Have a plan and think ahead.

I have not covered everything you need to be prepared, but hopefully it is enough to get you thinking. Remember, an investigator is like an alert crew waiting for the scramble order to come down — cocked and ready to go no matter what the scenario is. Your time on the SIB will be hectic enough. You do not need to make it any worse because you forgot something. The next time your phone rings, how will you answer the question, "Are you prepared?" ■

Ground Safety Award of the Quarter

*Staff Sgt. Jack N. Haughton
3rd Combat Communications Support Squadron
3rd Combat Communications Group
Tinker AFB, Okla.*

As the Safety representative for vehicle maintenance, Sgt. Haughton completely overhauled the vehicle maintenance safety program rewriting the job safety training outline to incorporate shop-specific safety requirements. He re-accomplished all the Air Force Forms 55, *Employee Safety and Health Records*, for the 10 personnel assigned. This standardized the layout and made it easier to track all safety-training requirements. Sgt. Haughton worked closely with the base bioenvironmental engineers to develop a workplace-specific hazardous communications program for the vehicle maintenance section that meets the requirements of both Air Force Occupational Safety and Health (AFOSH) Standard 161-21 and Tinker AFB Instruction 48-104. Sgt. Haughton's enthusiasm and experience allowed him to recognize a potential for personal injury due to moving parts during maintenance. To mitigate the risk, he ordered a complete lock-out/tag-out kit. Taking the lead on training for all shop personnel, he ensured familiarity with the program and certified the work-center training on their respective AF Forms 55. Sgt. Haughton also ordered a new material safety data sheet (MSDS) wall mounting kit and consolidated all MSDSs into one specific location within the work center. He thus ensured the section would be compliant with both AFOSH Standards 91-45 and 161-21. Additionally, he inventoried and ordered the required replacement items for the work-center spill kits, ensuring they are 100% ready for any emergency situation. Sgt. Haughton identified a facility circuit breaker box with numerous unmarked circuits that could result in electrical shock or burns when performing maintenance on the facility. He identified, marked and tagged each breaker's proper electrical circuit path so it could be quickly shut off in an emergency or during routine maintenance. While accomplishing the monthly November inspection of all safety equipment, Sgt. Haughton identified two wall mounting eyewash stations that were leaking saline solution. Within 2 hours of identifying the discrepancy, Sgt. Haughton repaired the existing eyewash stations and ensured they were ready for an emergency. His initiative saved the \$450 it would have cost to procure new stations. Always concerned for his coworkers, he volunteered to remove ice from the sidewalk of the group headquarters building after a recent ice storm. Sgt. Haughton's actions assured vehicle maintenance received zero deficiencies during the 3 CCSS's Annual Safety Assessment.

Hail & Farewell

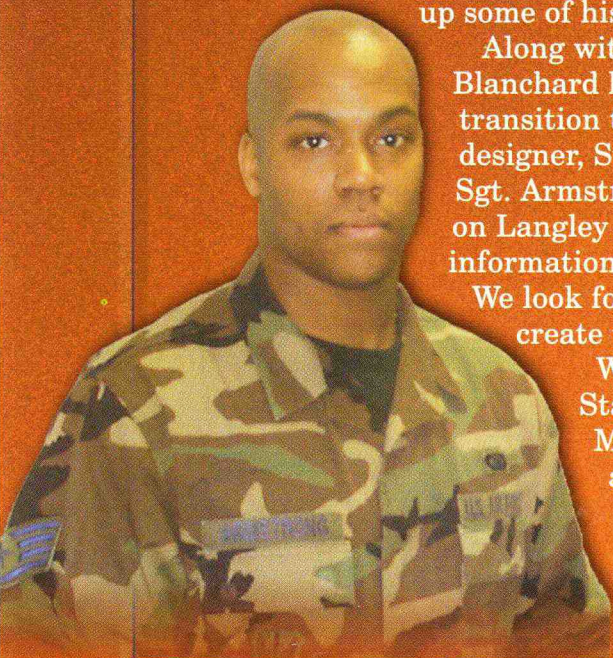
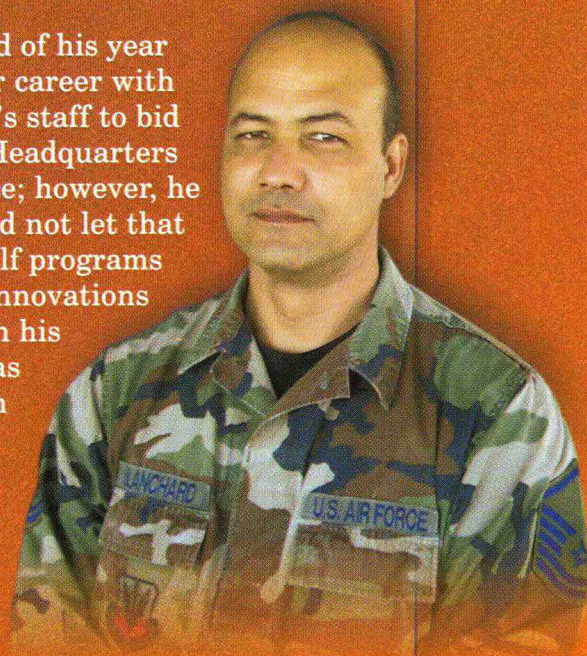
Master Sgt. Henry C. Blanchard, Jr., has reached the end of his year long tour with *The Combat Edge* and the end of his 24-year career with the U.S. Air Force and the time has come for the magazine's staff to bid him farewell. Sgt. Blanchard came to the magazine from Headquarters Air Combat Command Graphics with a wealth of experience; however, he knew little about the magazine-publishing business. He did not let that stop him from jumping in with both feet. He taught himself programs like PageMaker and PhotoShop and kept up on the latest innovations in graphics design. By the time Sgt. Blanchard flew solo on his first magazine, the transition appeared seamless and he was able to maintain the level of excellence that the publication had achieved.

Born in Wahiawa on the Hawaiian island of Oahu, Sgt. Blanchard's passion for the world of graphics and layout design began early in his life and led him to a career in visual information for the Air Force. His eye for detail, precision layouts and ability to graphically interpret the focus of each article greatly enhanced the safety message in each of the 12 issues that he produced. Sgt. Blanchard also served as the Webmaster for *The Combat Edge*, which was another skill he mastered without any formal training or previous experience. He frequently sacrificed personal time and goals to ensure that the best magazine possible was being produced on time for our thousands of readers. We appreciate all of his efforts and the initiative he took to keep our publication at the top of its game. Sgt. Blanchard plans to stay in the area after his retirement and finish up some of his personal goals before heading back to the islands.

Along with completing his final out-processing items, Sgt. Blanchard has been training and preparing the magazine for its transition to our new and very capable graphics and layout designer, Staff Sgt. Neil Armstrong. We are excited to welcome Sgt. Armstrong who comes to us from 1st Fighter Wing Graphics on Langley Air Force Base. He brings with him 8 years of visual information experience and has already hit the ground running.

We look forward to the graphics legacy Sgt. Armstrong will create with his confidence, initiative and imagination.

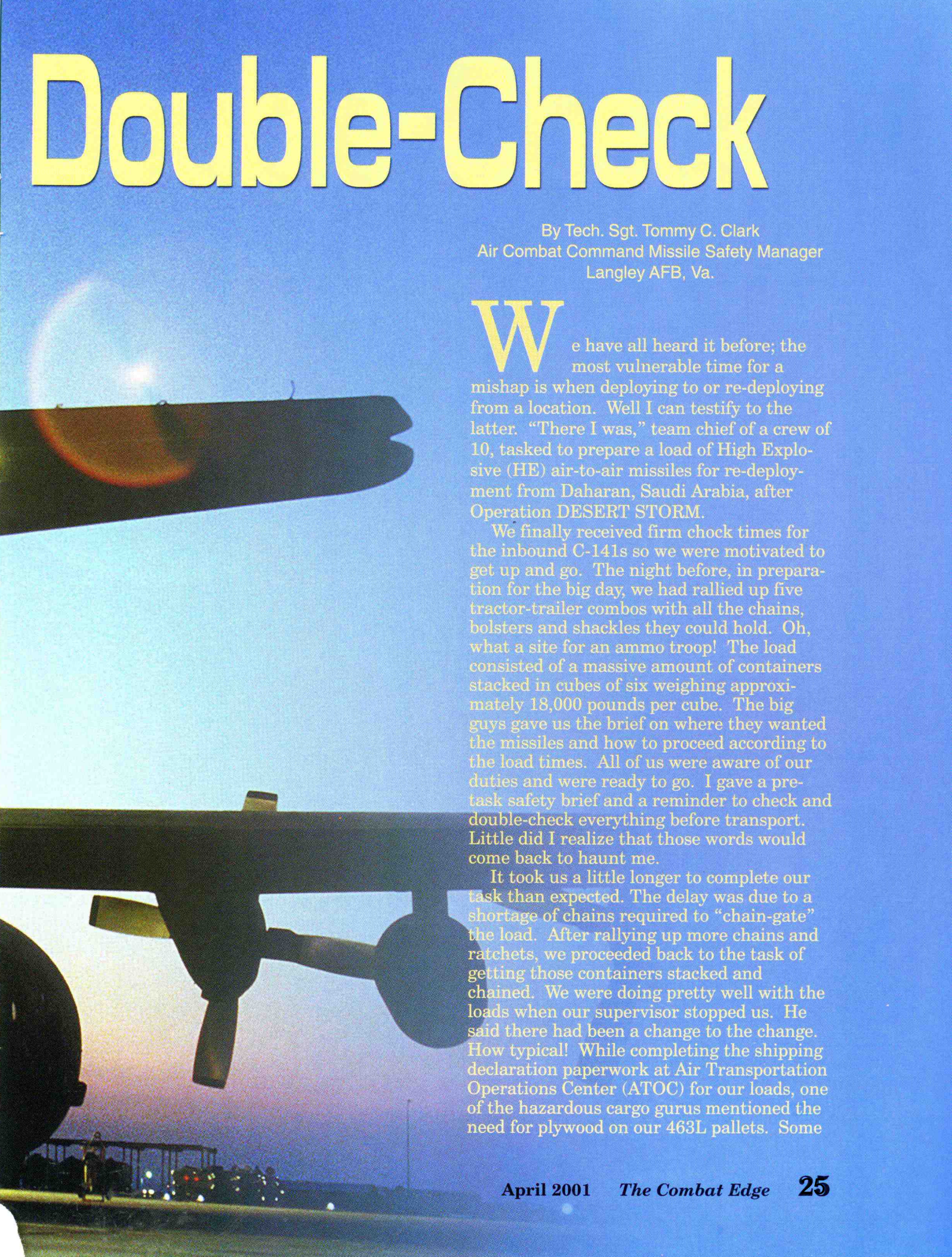
We hope that you will all join us in warmly welcoming Staff Sgt. Armstrong, and wishing the best of luck to Master Sgt. Blanchard, along with his wife, Jennifer, and their children, Rachael and Jonathan, as they venture into their new world of retirement. We salute you — Aloha!



Always



Double-Check



By Tech. Sgt. Tommy C. Clark
Air Combat Command Missile Safety Manager
Langley AFB, Va.

We have all heard it before; the most vulnerable time for a mishap is when deploying to or re-deploying from a location. Well I can testify to the latter. "There I was," team chief of a crew of 10, tasked to prepare a load of High Explosive (HE) air-to-air missiles for re-deployment from Daharan, Saudi Arabia, after Operation DESERT STORM.

We finally received firm chock times for the inbound C-141s so we were motivated to get up and go. The night before, in preparation for the big day, we had rallied up five tractor-trailer combos with all the chains, bolsters and shackles they could hold. Oh, what a site for an ammo troop! The load consisted of a massive amount of containers stacked in cubes of six weighing approximately 18,000 pounds per cube. The big guys gave us the brief on where they wanted the missiles and how to proceed according to the load times. All of us were aware of our duties and were ready to go. I gave a pre-task safety brief and a reminder to check and double-check everything before transport. Little did I realize that those words would come back to haunt me.

It took us a little longer to complete our task than expected. The delay was due to a shortage of chains required to "chain-gate" the load. After rallying up more chains and ratchets, we proceeded back to the task of getting those containers stacked and chained. We were doing pretty well with the loads when our supervisor stopped us. He said there had been a change to the change. How typical! While completing the shipping declaration paperwork at Air Transportation Operations Center (ATOC) for our loads, one of the hazardous cargo gurus mentioned the need for plywood on our 463L pallets. Some

of the loadmasters were rejecting loads because they considered metal containers loaded on metal 463L pallets hazardous. Supposedly, this condition would increase the possibility of static electricity production when or if the container shifted. Static electricity and explosives do not mix! With this change, we lost precious time and had to hustle up to install plywood on all the previously loaded pallets. I decided to break up my crews to save time. Half worked on the download and the others proceeded with uploading the remaining assets.

Now nothing is more demoralizing to a troop than to get the word that they have to re-accomplish work for a reason that was not their fault. I could tell the morale had been affected because some of the energy they had earlier had been lost. Some might say fatigue was the cause, but I knew these guys better. My role changed from a participant to supervisor, going to each site and making sure everyone was proceeding according to the new plans. We finally got all of the loads done and called for the ATOC final inspection prior to transferring everything to the Hot Cargo Pad (HCP). They blessed what they saw and gave us a show time that was 3 hours out. This gave us enough time to get some chow, shower and put on the last clean set of uniforms we had. We all gathered again 2 hours later and were ready to go. We threw our "civvy" bags into our supervisor's pickup and got a final brief prior to the convoy. After the brief, we dispersed and headed to our rigs with our shotgun sidekicks and started the line up.

I had the lead and started the procession to the HCP. A convoy of loaded rigs is a beautiful site! We arrived at the HCP 1 hour prior to the aircrafts' show time and stood by waiting for further instructions. While we waited, we decided to start breaking the transport chains so the K-loaders could pull up and start delivering the loads. I did not release my chains because I had to get the shipping documents reviewed by the ATOC supervisor prior to moving anything. That is when he told me that we would not be downloading the vehicles where we were. Instead, he wanted us to go, one-by-one, 500 yards aft of where we were. This was not a problem and I decided that my load would go first. I told the guys what was happening and they did not see any problems either — just as long as the planes still arrived

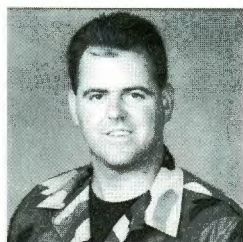
as scheduled. Since I had not touched my chains, I went over to my truck and started to roll. As I started pulling my heavy load and got ready to change gears, I heard someone scream "Hey! STOP!!" I turned and looked to my right and saw my partner frantically waving his arms and pointing at my trailer. As I looked around I heard — and felt — a rumbling. I was amazed to see my load shifting from the back of the trailer towards the gooseneck. I said to myself ... well, I cannot repeat what I said here. All I felt was approximately 35,000 pounds impacting that gooseneck. The force of the impact was so hard it made the tractor tires skip even as I stood on the brakes. I consider myself a rather brave guy but at that moment — I WAS SCARED. Luckily, as quickly as it all happened, it was all over. I sat there for a moment and tried to gather myself. I do not know why, but the first thought that came to my mind was, "I wonder if anyone else saw what just happened." My partner jumped up in the passenger window and asked if I was okay. I slowly looked over to him and said the only thing that was on my mind, "Who took the chains off my load?!" He said nothing and climbed down. I patiently stepped out of the cab to assess the damage. To my surprise, the load had stayed somewhat intact. The containers had only shifted approximately 6 inches on the 463L pallets, which meant they were still good enough to transport. This brought somewhat of a sigh of relief.

"How did this happen?" you ask. Well, my trailer was a rollerized version designed to roll its load directly onto an aircraft or K-loader. If not properly secured, the pallets will roll, almost freely, off the trailer. Someone had tried to be helpful and had taken the chains off my load while I was with the ATOC supervisor. In my rush to get the job over with and get on the plane to go home, I did not double-check my load before getting in the cab to move my truck. This event could have been catastrophic and once again reinforces that the most likely time for a mishap to occur is during deployment or re-deployment scenarios. We must remember that our job is not over until we are actually sitting at home in our favorite chair. Don't get caught up in rushing to get there. It can result in ending lives, destroying or damaging valuable equipment and negatively impacting promising careers. Always take the extra time you need to double-check your work! ■



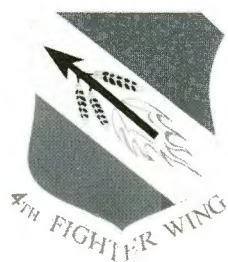
COMMANDER'S AWARD FOR SAFETY

9th Air Force / United States Central Command Air Forces
Shaw AFB, S.C.



SAFETY SUSTAINED SUPERIOR PERFORMER AWARD

SSgt Benjamin R. George IV
86th Fighter Weapons Squadron
Eglin AFB, Fla.



SAFETY OFFICE OF THE YEAR AWARD- CATEGORY I

4th Fighter Wing
Seymour Johnson AFB, N.C.



SAFETY OFFICE OF THE YEAR AWARD - CATEGORY II

552nd Air Control Wing
Tinker AFB, Okla.



DISTINGUISHED CHIEF OF SAFETY AWARD

Capt Trevor J. Boyko
85th Group
Keflavik NAS, Iceland



DISTINGUISHED PILOT SAFETY AWARD

Capt Barry R. Cornish
58th Fighter Squadron, 33rd Fighter Wing
Eglin AFB, Fla.



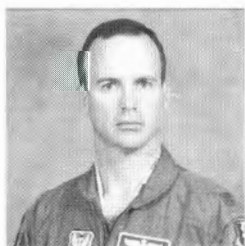
DISTINGUISHED AIRCREW SAFETY AWARD

Lt Col Jeffry F. Smith, Capt Todd M. Valentine,
Capt Brian S. Ogawa, Capt Kenneth R. Boillot
37th Bomber Squadron, 28th Bomber Wing
Ellsworth AFB, S.D.



OUTSTANDING ACHIEVEMENT SAFETY AWARD

347th Wing
Moody AFB, Ga.



DISTINGUISHED FLIGHT SAFETY OFFICER AWARD

Maj T. Chance Lovette
33rd Fighter Wing
Eglin AFB, Fla.



DISTINGUISHED FLIGHT SAFETY NCO AWARD

MSgt Thomas F. Lyman
1st Fighter Wing
Langley AFB, Va.



DISTINGUISHED CREW CHIEF OF THE YEAR AWARD

SSgt Aaron P. Nanney,
SrA Christopher M. Holmes
333rd Fighter Squadron, 4th Fighter Wing
Seymour Johnson AFB, N.C.



DISTINGUISHED FLIGHT LINE SAFETY AWARD

A1C Ricardo L. Flores
552nd Aircraft Generation Squadron, 552nd Air Control Wing
Tinker AFB, Okla.



DISTINGUISHED GROUND SAFETY ACHIEVEMENT AWARD

SSgt Leo C. Wheeler, Jr.
944th Maintenance Squadron, 944th Fighter Wing
Luke AFB, Ariz.



EXCEPTIONAL GROUND SAFETY LEADERSHIP AWARD

Mr. Timothy M. Edwards
4th Fighter Wing
Seymour Johnson AFB, N.C.



SUPERIOR PERFORMER IN GROUND SAFETY AWARD

SSgt John P. Carr
355th Component Repair Squadron, 355th Wing
Davis-Monthan AFB, Ariz.



CMSGT PAUL A. PALOMBO AWARD FOR DISTINGUISHED GROUND SAFETY NEWCOMER

SSgt Daniel J. Fabo
27th Fighter Wing
Cannon AFB, N.M.



ANNUAL UNIT GROUND SAFETY AWARD - CATEGORY I

55th Wing
Offutt AFB, Neb.



ANNUAL UNIT GROUND SAFETY AWARD - CATEGORY II

85th Group
Keflavik NAS, Iceland



ANNUAL TRAFFIC SAFETY AWARD - CATEGORY I

4th Fighter Wing
Seymour Johnson AFB, N.C.



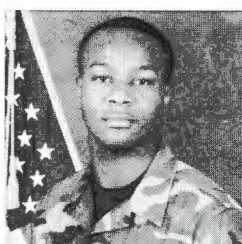
ANNUAL TRAFFIC SAFETY AWARD - CATEGORY II

53rd Wing
Eglin AFB, Fla.



EXCEPTIONAL WEAPONS SAFETY INDIVIDUAL AWARD

MSgt Kevin B. Walters
53rd Wing
Eglin AFB, Fla.



DISTINGUISHED WEAPONS SAFETY ACHIEVEMENT AWARD

SSgt David R. Ashley
A1C Antonio L. Cooper
79th Fighter Squadron, 20th Fighter Wing
Shaw AFB, S.C.



OUTSTANDING UNIT WEAPONS SAFETY AWARD - CATEGORY I

509th Bomber Wing
Whiteman AFB, Mo.



OUTSTANDING UNIT WEAPONS SAFETY AWARD - CATEGORY II

33rd Fighter Wing
Eglin AFB, Fla.

