

The Combat EDGE

September 2001



School Bus
SAFETY

The Combat EDGE

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Cover photo by TSgt. Jack Braden

ACCent on Safety

JOINING TEAM SAFETY

Hi, I'm Colonel Kevin Smith, the new Chief of Safety for Air Combat Command (ACC). I want each of you to know that "we are here to help." If that sounds a bit strange coming from a staff-puke who has not recently camped out on your base, you are right ... but I truly mean it! We are all on the same team because it takes every single person in the command to (further) drive-down our mishap rates.

ACC Safety has the experts with the tools, techniques and expertise to help everyone maintain the strongest safety programs. By working together, these programs will help preserve our precious resources: people, aircraft, and equipment.

Many of the lessons we have learned in aviation come from the school of hard-knocks. A lot of them have resulted in ACC Instructions, but we can do more to keep from repeating the mistakes that lead to mishaps. That is where you come in. We need to hear about your experiences, concerns, ideas, and successes. Sharing your "lessons learned" and incorporating them into our safety programs will keep us all at the top of our game. Do not hesitate to share your experiences with us.

Again, I am glad to be joining the ACC Safety team and want you to consider us all members of your team! If we can help you solve a problem or a safety issue, my phone number is DSN 574-8800.

*Colonel Kevin Smith
ACC Chief of Safety*



School Bus Safety



As summer days grow shorter, communities across America will soon be observing that timeless annual ritual: the first day of school. It is a time when parents breathe a sigh of relief and students and teachers anticipate new beginnings and new challenges.

Unfortunately, the beginning of school is also a time when children are at increased risk of transportation-related injuries from pedestrian, bicycle, school bus and motor vehicle crashes. This happens because there are more children on the road each morning and afternoon and many drivers' patterns change. Shorter daylight hours make it especially difficult to see young pedestrians and bicyclists. So as schools open their

doors, it's time for everyone — motorists, parents, educators and students — to improve their traffic safety practices.

The familiar yellow school bus has become one of the most powerful icons in American society. Day-in and day-out, the nation's 418,000 yellow buses travel more than 4.5 billion miles a year at a cost of nearly \$10 billion. They safely carry 24 million children — nearly half of all the nation's children — to and from school.

Young people were first transported to school at public expense in the late 19th century. They started in horse-drawn wagons and later traveled in converted trucks. The first vehicles designed specifically for pupil transportation did not become available until the 1920s and 1930s. Throughout

this early period, safety continued to be a concern, culminating in the establishment of the first set of national school bus standards in 1936.

"School bus transportation continues to be one of the safest forms of transportation"

Unfortunately, the beginning of school is also a time when transportation-related injuries from pedestrian, bicycle, school



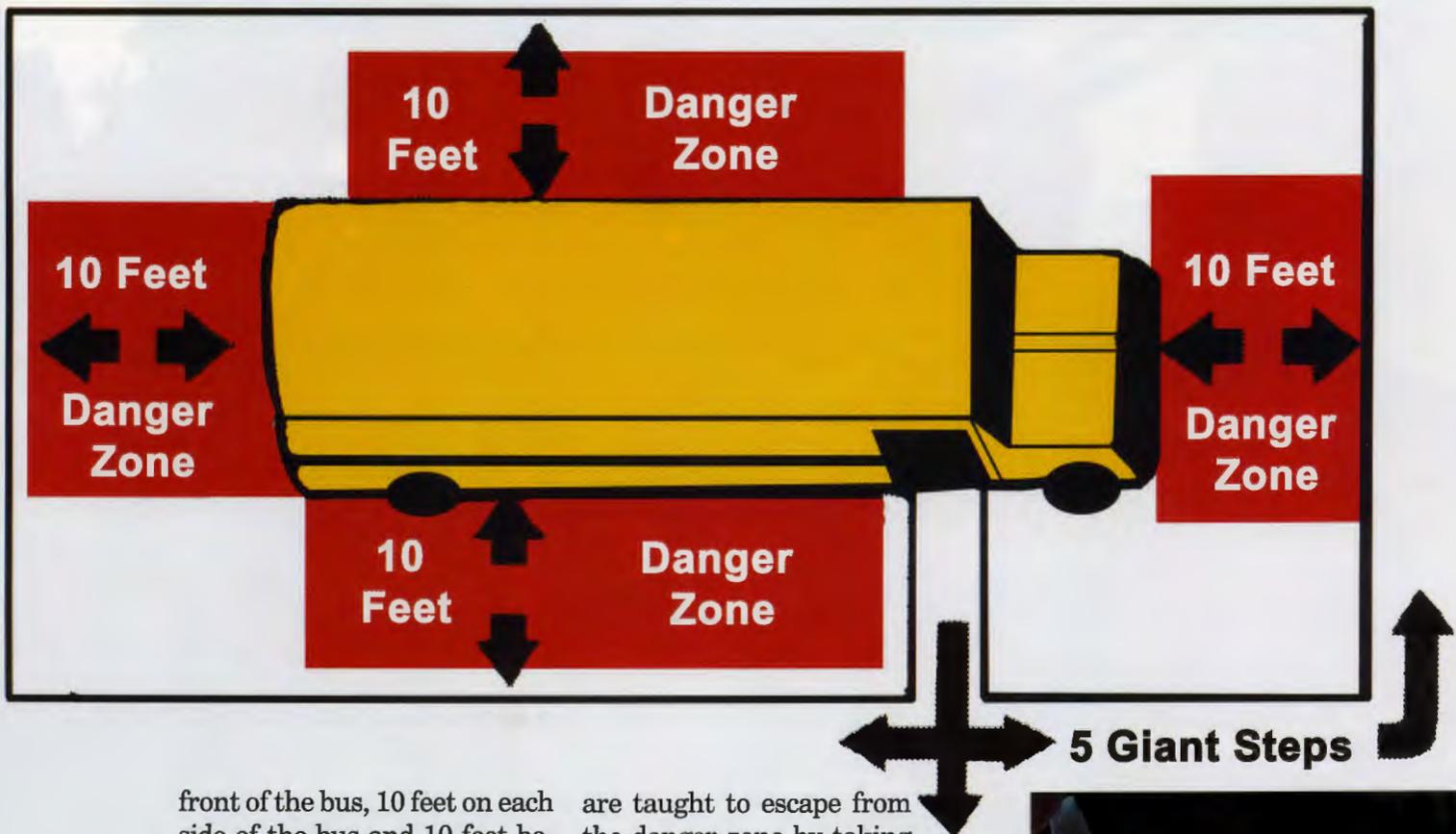
Photo by SSgt. Jack Braden

according to the National Highway Traffic Safety Administration. It is far safer to ride in a yellow bus than in the family car, for instance. This superb record is the result of a consistent cooperative effort by a host of individuals and

groups. Everyone with a stake in student transportation — parents, teachers, drivers, school administrators, transportation managers, bus manufacturers and government officials — has a role to play.

While school buses can be proud of their safety record, there are still aspects of school bus transportation that are dangerous to children. More children are hurt outside a bus than inside one. Getting on and off the bus is the most dangerous part of the school bus ride. This loading and unloading area is called the “danger zone.” This area extends 10 feet in

children are at increased risk of school bus and motor vehicle crashes.



front of the bus, 10 feet on each side of the bus and 10 feet behind the bus. The danger zone is where children are at greatest risk of not being seen by the bus driver. The child who bends over to retrieve a dropped school paper, or who walks too close to the bus while crossing the street, is at greatest risk of becoming the next statistic of this danger zone.

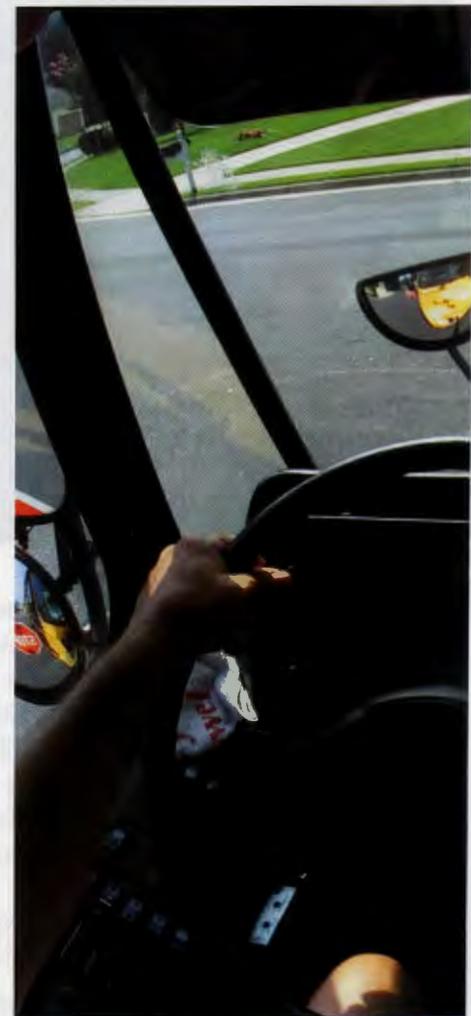
The risks of the danger zone can be minimized. Students should arrive at the bus stop 5 minutes early. They should stand at least five giant steps (10 feet) away from the edge of the road and wait until the bus stops, the door opens and the driver says it is OK before they step onto the bus.

Students should also be careful that clothing with drawstrings and book bags with straps or dangling objects do not get caught in the handrail or door when exiting the bus. In many school districts, children

are taught to escape from the danger zone by taking five giant steps as soon as they leave the bus. If they must cross the street after exiting, they are taught to cross in front of the bus; never behind the bus.

It is important for students to understand that the bus driver must be able to see them and they should be able to see the driver while in the danger zone. The children can do this by maintaining eye contact with the driver at all times. If they drop something beside the bus, your child should tell the bus driver **BEFORE** attempting to pick up the item. If they don't, the bus driver may not see the child and begin to drive away.

Parents and other adults must also do their part. For instance, most motorists need to learn to share the road with school buses. They must stop when the bus stops to take on or let off passengers. If we all



do our part — if motorists heed school bus warning lights, bus drivers drive defensively, parents help their children learn to ride safely and children learn to avoid the bus's danger zone — we can increase the safety of that yellow bus ride to and from school.

Safety precaution education is the best way to keep your child safe this school year. Get involved and get your children involved. The more you know the safer you and your children are. ►

Compiled from the National School Transportation Association (NSTA) and the National Highway Traffic Safety Association



Photo by SSgt. Jack Braden



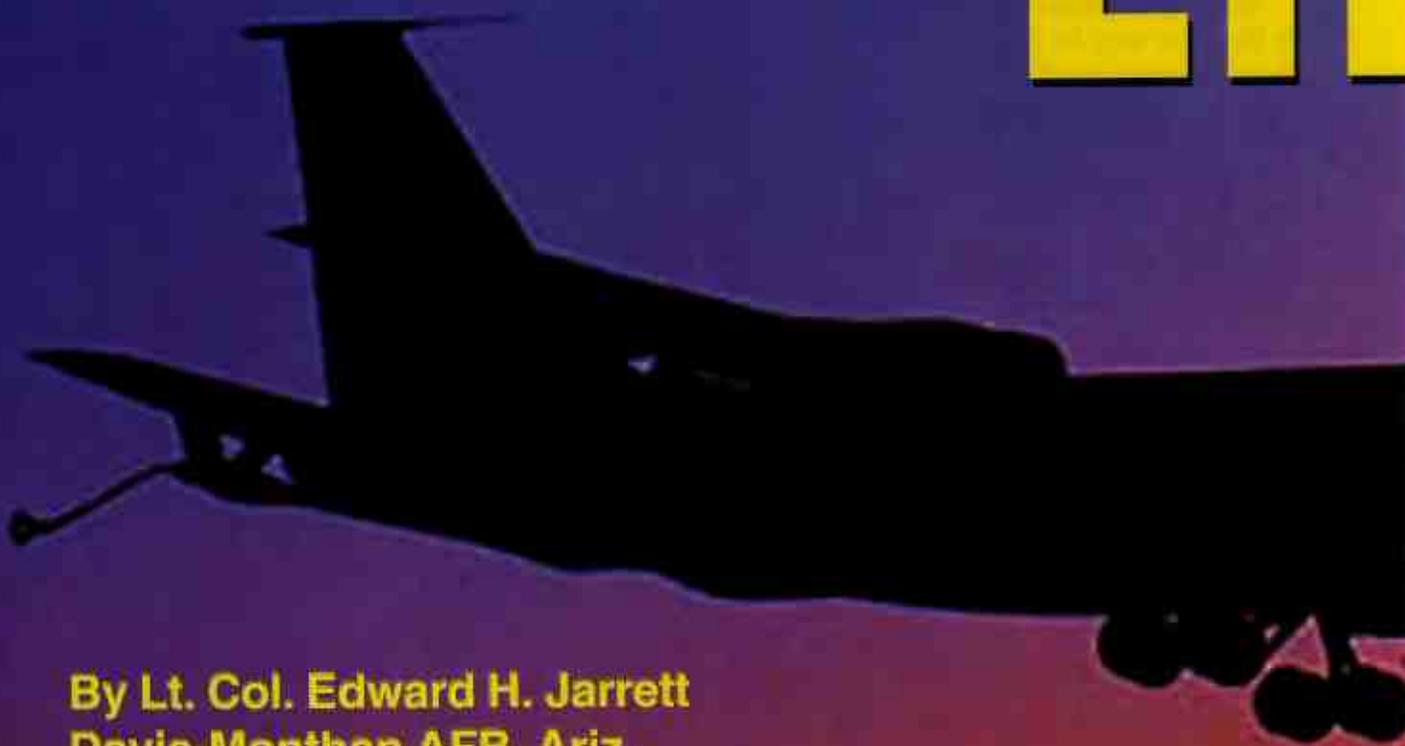
Photo by SSgt. Jack Braden



Motorists Should:

- Be aware it is illegal in every state to pass a school bus stopped to load/unload students.
- Know and understand laws governing motorists' driving behavior near a school bus.
- Learn the "flashing signal light system" that school bus drivers use to alert motorists if they are going to stop to load/unload students:
 - Yellow flashing lights indicate the bus is preparing to stop to load or unload children. Motorists should SLOW down and prepare to stop their vehicles.
 - Red flashing lights and extended stop arms indicate that the bus has stopped and children are getting on or off. Motorists MUST stop their cars.
- Begin moving only when the red flashing lights are turned off, the stop arm is withdrawn and the bus begins to move.
- Watch out for young people who may be thinking about getting to school, but may not be thinking about getting there safely.
- Slow down:
 - Watch for children walking in the street, especially if there are no sidewalks in the neighborhood.
 - Watch for children playing and gathering near bus stops.
- Be alert:
 - Watch for children arriving late for the bus, who may dart into the street without looking for traffic.
 - When backing out of a driveway or leaving a garage, watch for children walking or biking to school.

En



**By Lt. Col. Edward H. Jarrett
Davis-Monthan AFB, Ariz.**

I joined the 12th Air Force safety staff about 6 months ago and amazingly ran into an old fellow KC-135 navigator. His most vivid memory of our past exploits was a long KC-135 trip we took from Beale Air Force Base, California, to Kadena Air Base, Okinawa, back in the mid-1980s. He had been my flight commander on that mission. I had almost forgotten about that particular deployment, but the events came back

quickly as we reminisced. Back then, I was a young aircraft commander who would have described myself as being pretty safety minded ... you be the judge.

The venerable KC-135Q model that we flew was a modified tanker designed to support the SR-71 air refueling requirements. Every couple of weeks, we would deploy crews, aircraft and parts to our two detachments. One was located at Kadena and the other at Royal Air Force

Mildenhall in the United Kingdom. The mission in question was one of those regular swap-out sorties to Kadena — well almost ...

Typically, due to the fuel and performance constraints of the mighty J-57-equipped tanker, we would have to make at least one refueling stop either at Eielson Air Force Base, Alaska, or at Hickam Air Force Base, Hawaii, before proceeding to Kadena. On this particular mission, we had an addi-

Pushing Your Endurance Limits



tional stop at Anderson Air Force Base, Guam. Even with three full crews aboard, we knew this was going to be a long mission. Some crew swap-out dynamics to support other taskings added to the urgency of our timeline.

The guidance under the old Strategic Air Command for crew duty days was something like 20 hours for a regular crew consisting of an aircraft commander, copilot, navigator and boom operator. An augmented crew with an

additional aircraft commander, navigator and boom operator could go for 26 hours. Based upon the winded flight plans and our planned turn times at Hickam and Anderson, we felt confident that we would be able to complete our deployment legs within the allowed 26 hours. Hack!

After about 4.5 hours of flying, we arrived without incident at Hickam and were expecting about a 2-hour turn for fuel. Luck would

have it that business was booming, and we lost over an hour turning the jet. Tick, tick, tick ...

No big deal. We figured we could make it up on our 6- to 8-hour leg to Anderson. And we did, but only by burning a lot of extra gas trying to keep up with the winds and landing code 3 for a minimum equipment list required item. Then our time margins were further shaved by an additional hour waiting for the new replacement part for



Photo by SrA. Jeffrey Allen

the copilot's instrument power generator. And, yes, the third crew — my crew — had the final leg into Kadena. The clock was ticking faster.

At this point in the mission, we all felt that we were

captain, I felt an urgency to get our colonel to his destination. He asked a couple of times how we were doing on time, and I assured him that we should be able to get to our final destination within

off, my navigator spun the winds and we crosschecked our single inertial navigation system for confirmation of our time to landing. That is when we had to face reality. The stronger than expected

... stronger than expected headwinds indicated we were not going to make it ...

being safe by pushing on to Kadena. No one saw the need to stay overnight in Anderson. Besides, that would have meant dealing with all the extra crew and duty passengers, and it just so happened that our Director of Operations (DO), now known as the Operations Group Commander, was one of those passengers. Even though our DO made no effort to push our crew, as a

our crew duty time ...

Hatches buttoned up and engines running, we were tired, but ready to leave Anderson. Looking at our watches and counting the minutes instead of the 3.5 hours it would take us to make it to Kadena, we were a little less confident, but felt it was doable — just barely. Anxiously, we broke ground and headed for Kadena.

Shortly after we leveled

headwinds indicated we were not going to make it and changing everyone's watches while they slept was not going to change the fact that we were going to land late.

Two hours into the flight, I looked back and the only other person awake was my boom operator. Even though my copilot and I had discussed his catching a few minutes of rest before starting the descent for Kadena,

it was still an eerie feeling to know how exhausted folks really were. If something had happened, we would have probably been moving in slow motion until those first doses of adrenaline kicked in. Thankfully, our jet did not hiccup, and we managed a very quiet and uneventful approach and landing.

While we were taxiing to parking, my flight commander tapped me on the shoulder and asked, "How'd we do?" With regret and a certain amount of disappointment, I told him that we had missed our 26-hour crew limit by 20 minutes. After we opened up for customs, the DO came up and asked me the same question.

I responded nervously, "What would you like to hear, Sir? The book answer or what we actually flew?" He was clear, and I repeated what I had told my flight commander. He thanked me and that was the last I heard of it — until I returned home.

My crew, my flight commander and the other crew members onboard learned some valuable lessons that should have been obvious to us all, but we missed them by leaning forward to get the mission

completed. Looking back, my sense of risk management was not very well developed and my assessment of potential risk was pretty poor. Although supportive, the presence of the DO and the perceived importance of getting to our destination further crippled our crew's sense of risk exposure. Finally, the vagaries of stronger-than-planned winds and an unexpected maintenance problem sealed our crew duty day violation.

Wisely, upon returning to home station, the DO immediately issued a Flight Crew Information File or FCIF notice restricting crews to two legs for deployments to Kadena with a required Re-

main Over Night or RON if three legs were planned. The DO also understood that by taking some of the latitude away from the crews, he could mitigate the risks resulting from their willingness to push the limits of that long crew duty day period.

Nearly 10 years later, I had the opportunity to be a part of a mishap investigation where being late was a driving factor for a set of compounding errors that resulted in the loss of an airframe and all onboard. It was pure luck that stopped me from being the subject of someone else's investigation. Luck is a fickle thing — don't rely on it to get you to the safe end of your mission. ►



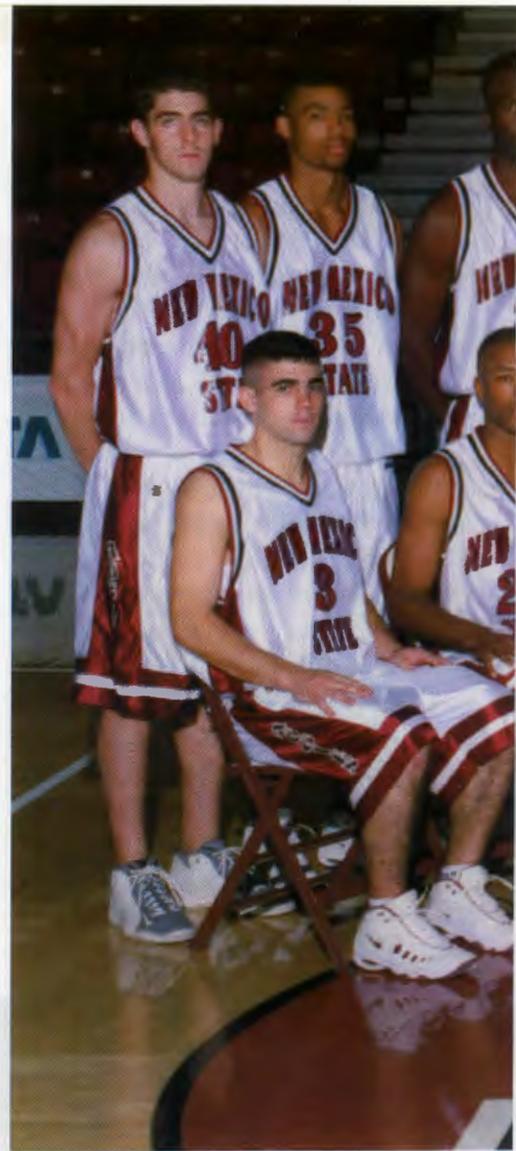
Photo by SrA. Jeffrey Allen

I have two sons. Both are alive and for that I am grateful — especially after what happened on a Saturday evening in 1997. My older son Ryan was away at college while the other was home and a junior in high school. Ryan was the number two draft pick for the Cleveland Indians. Then, everything changed ...

My wife and I had gone out in the early evening to a local Mexican restaurant and were really enjoying each other's company. I remember conversing about how blessed and fortunate we were. We were boasting to each other about our genuinely great life. When we left the restaurant, I noticed the weather was perfect. The temperature was in the low 80's, and the evening sky

to come to the hospital right away. After a lot of coaxing, the emergency room nurse finally told me that my son had been hit by a car and was in a coma.

At that point, everything blurred. My wife and I drove the 65 miles to the hospital in what seemed to be slow motion. I did not know how to think or even pray. It was the longest trip I have ever made in my life. When we arrived



End of a Dream ... I

By Mr. Jerry McDermott, Holloman AFB, N.M.

was filled with billions of stars. The Big Dipper and the Constellation Orion seemed so close you could touch them. It was a wonderful evening.

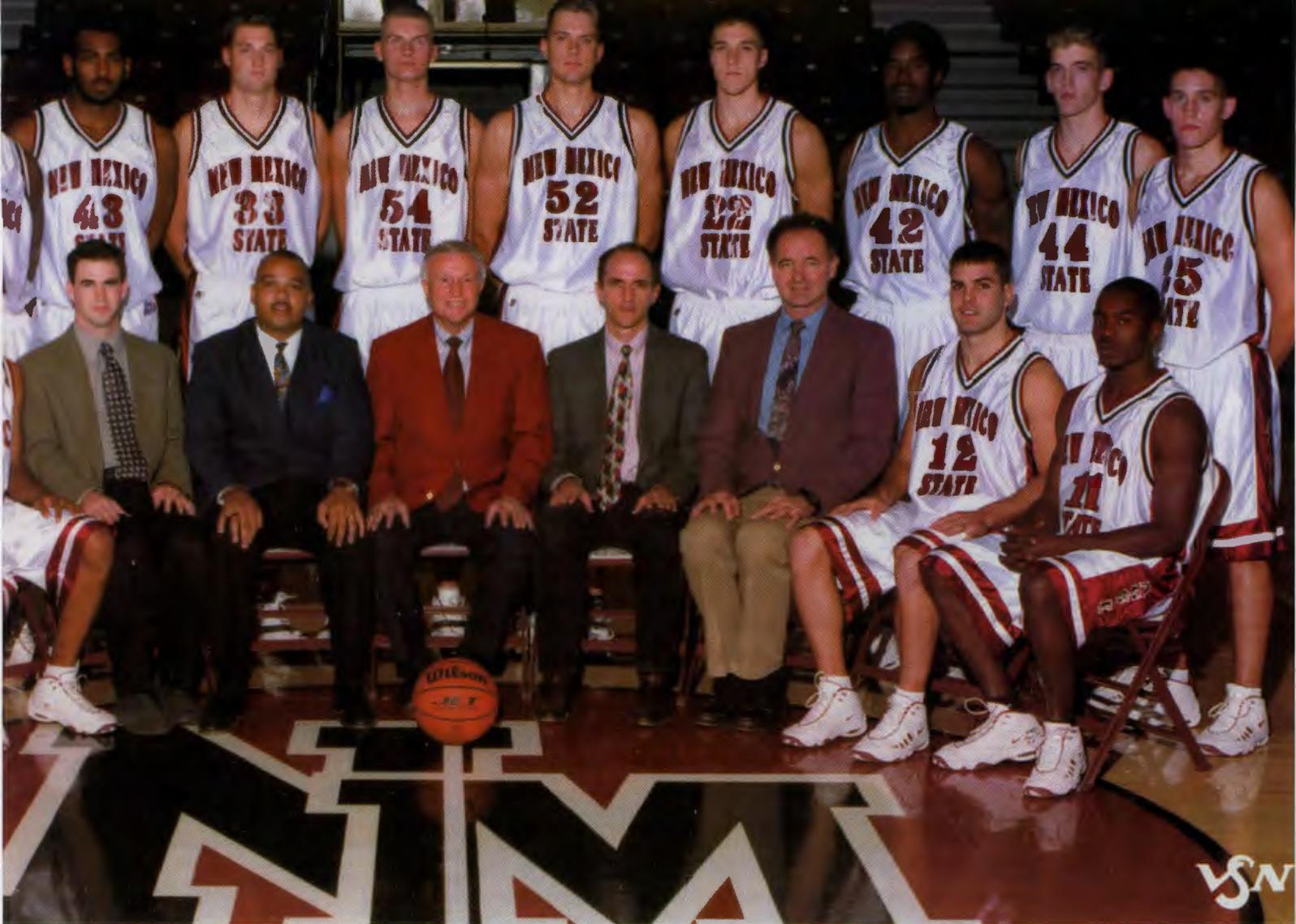
At 12:30 a.m., the chilling sound of the phone ended our peaceful evening. It was the type of call that all parents fear. A young hospital nurse told me that my older son Ryan had been in an accident and was hurt. I asked how badly. The nurse said she could not tell me over the phone, but urged me

at the hospital, we immediately went into the emergency room and saw Ryan lying on the emergency room gurney, strapped down with a respirator allowing him to breath. He was still dirty from the accident. The room was filled with gauze and other remnants from his emergency care. There were bloodstains on the floor.

At 4:00 a.m., Ryan was transported to an Army Medical Center and placed in high-

level intensive care. The next few days were a roller coaster of good and bad news.

The following evening the doctor made our family leave and get a hotel room to sleep. He promised he would call if there were any changes. When I awoke the next morning, I sat on the bedside, depressed, scared and hopelessly wondering "what if." My younger son sensed my mood, put his arm on me and said, "Dad, it's going to be alright."



...the Beginning of Life

They didn't call." Wow! What a bolt of lightning! I just received inner strength from my youngest son.

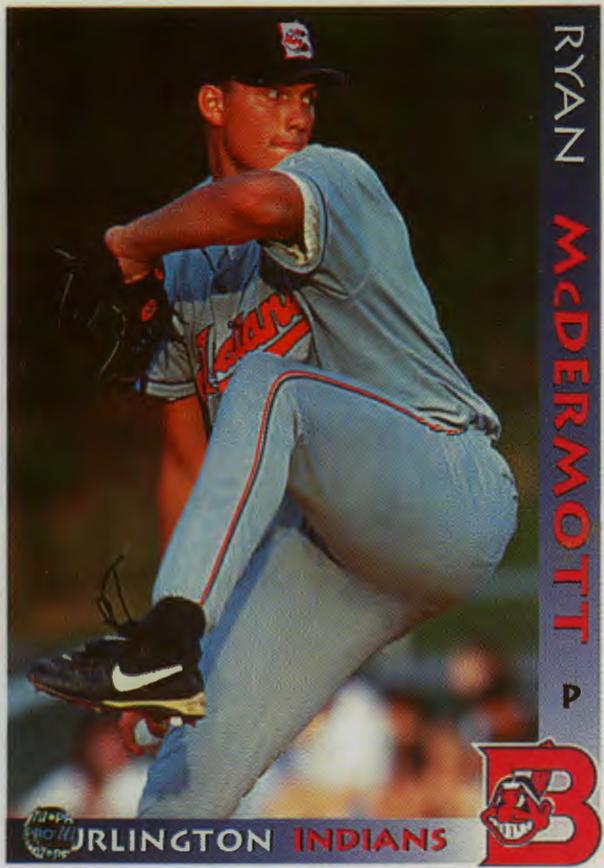
Ryan came out of his coma 4 days later and had a lengthy recovery. Today he is back in school and will be a junior majoring in biochemistry. He no longer plays basketball and will never make it to the Cleveland Indians as a player; however, those things are all minor. He's alive!

I wanted to share this story, because of how the accident happened. Decisions were made that day that will affect the rest of Ryan's life. The consequences of those decisions happened in the blink of an eye. That is why it is so important to assess the risks of the decisions we make before we imple-

ment those decisions. This accident did not have to happen. I hope by retelling it here, others can benefit.

That night Ryan decided to stop and help the victims of an earlier accident. While he was helping the injured out of their car, another car struck the wrecked car and bounced

After the accident, Ryan, number 52, returned for a time as a power forward for the New Mexico State Aggies basketball team. As a pitcher, he was the number 2 draft pick by the Cleveland Indians in the 1996 Major League Baseball draft. With his sports days behind him, Ryan now hopes to attend medical school.



RYAN MCDERMOTT P

Ryan across an interstate. The scene was not secured; it was evening time and the driver that hit the wrecked car simply was not paying attention.

My son did not realize the risks that night when he stopped to help the victims of the earlier accident. If you ever find yourself in a situation like Ryan did, there are safety precautions that you can take to keep yourself as safe as possible. You can wait for the police to arrive, put out flares or use another person to flag down and warn oncoming traffic. Never assume that other drivers will see you. It is important for all of us to realize the risks. Every time you make a decision, you accept risks that might affect your family more than you can ever

imagine. Take nothing for granted and make good decisions.

As the Chief of Ground Safety at Holloman AFB, New Mexico, I have investigated too many fatal mishaps and hundreds of lost time mishaps. Before Ryan's accident, I always thought I felt bad about what happened to other people. Now I know there is a "whole new" level of bad. Every siren I hear comes in loud and clear, and I immediately do a mental check trying to account for every family member. I no longer take anything for granted.

The next time you see an accident, think about your decisions and make sound ones — your family is depending on you. My son has been given a second chance. You might not be so lucky. ▶

The author, his wife Linda with his sons Ryan (L) and Christopher (R)

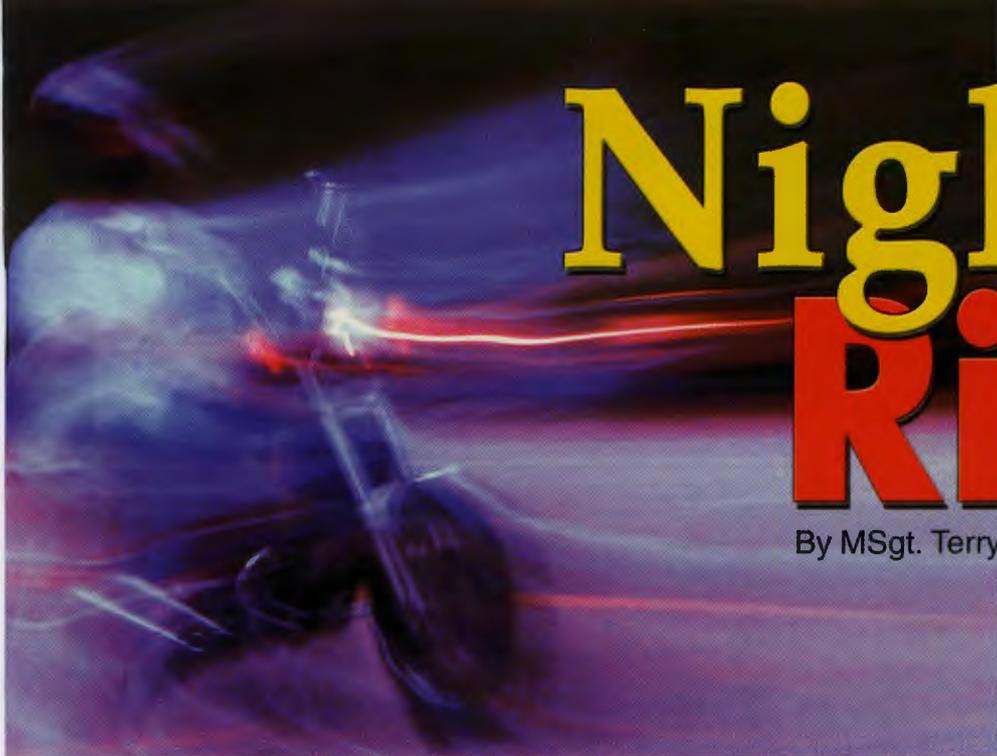


Safety Note

Since March 2001, three ACC airmen have been fatally injured when drivers crossed the centerline and hit another vehicle head-on. The hazards on our highways are real and need to be factored into our Personal Risk Management (PRM).

Night Rider

By MSgt. Terry V. Haskew, Edwards AFB, Calif.



I know you did not mean to be gone so long, but the enjoyment of riding on such a beautiful, sunshiny day has led into a pre-dusk return. Good thing you had the foresight to pack your clear shield even though the tinted one sure did come in handy on those sharp turns in the mountains when the sun suddenly appeared directly in front of you.

As you realize it will be night-fall soon, you pull over and replace the shield using care not to scratch it. This break on the side of the road has several purposes. First, it is an opportunity to let your eyes adjust to the changing situation. It also gives you a chance to stretch your legs before they cramp up as the temperatures begin to decrease. Finally, it is a good idea to make another check of the bike before night falls and you have to stop again and go fumbling with a flashlight to repair something along the side of the road. As you make this check, watch out for those hot surfaces on your bike and do not forget to check your lights — you'll need them!

Face it. It will be dark soon, which increases the challenges of safety so there is no need in rushing at this point.

You have made the transition and it is time to go. The road is pretty deserted since it is a Sunday and most folks in this area are sitting down to dinner. As you start out, you know you only have a little farther to go. You commend yourself on good preparation, smooth handling skills throughout the day and — oh yeah — gotta go to work tomorrow. Your attention drifts away

mind is focused and back in the game. What was that “trick” someone told you for oncoming traffic at night? Isn't it the white line over on the right? You can briefly divert your attention to that while the car is passing, but do so only after you have made sure the car is on its side of the road. Remember what you learned in that “dumb” motorcycle safety class about visual directional control. Do not fixate on the line or you will be riding over it and off onto that nasty 3-inch shoulder drop off.

What was that “trick” someone told you for oncoming traffic at night?

from the task at hand just as a car comes around the corner with its high beams on. “Geeeee, where did the road go!” Your first mistake was looking directly into the headlights. Amazingly, your subconscious remembered where the road was and you maintained your course. “Whew!”

OK, now you are ready for the next one that comes along. Your

Well, you finally made it home. While relaxing, you relive the ride. Boy, that momentary lapse of mind control, combined with the change in riding conditions, sure was hairy. That will not happen again. “What was I thinking? Oh, that's right. Gotta go to work tomorrow! Think I'll take the bike.” ▶



A-10 Thunder

Primary Function: Close air support • Contractor: Fairchild
Wingspan: 57 feet, 6 inches • Speed: 420 miles per hour • Ceiling:



Thunderbolt II

Republic Co. • Length: 53 feet, 4 inches • Height: 14 feet, 8 inches
10 feet • Range: 800 miles • Crew: One • Date Deployed: March 1976

Preparation is Key to Safe Hurricane Season

POPE AFB, N.C. — As we find ourselves into another hurricane season, we are reminded of the awesome power these storms produce and the devastation that is left in their wake. While we have no control over what Mother Nature throws our way, we can take steps to lessen the impact on our families. In the event that a hurricane threatens us here, careful planning will help ensure we are as prepared as possible.

Watches/Warnings

A watch is issued when there is a threat of hurricane conditions within 24 to 36 hours. A warning is issued when hurricane conditions — winds of 74 miles per hour or greater — are expected in 24 hours or less.

Hurricane Conditions

HURCONs are used here to provide a more detailed indication of the hurricane's arrival. HURCON I is the same as a warning. HURCON II through V are the same as a watch.

- **HURCON V:** Readiness conditions declared by the installation commander
- **HURCON IV:** Winds of 50 knots or more are

expected within 72 hours

- **HURCON III:** Winds of 50 knots or more are expected within 48 hours
- **HURCON II:** Winds of 50 knots or more are expected within 24 hours
- **HURCON I:** Winds of 50 knots or more are expected within 12 hours

Hurricane Safety

You will normally have plenty of time to prepare for the storm's arrival. Do not wait until the last minute to get ready.

- Store drinking water in clean containers.
- Ensure you have enough non-perishable food for a minimum of 1 week.
- Prepare an emergency disaster supply kit with all the items you may need.
- Secure all loose outdoor items such as garbage cans, garden tools, signs and lawn furniture.
- Board up all windows larger than 3 feet by 3 feet.

- If advised to evacuate the area, follow the directions of the local authorities.

These are just a few tips to follow during hurricane season. Additional information can be found on the Internet, from the Federal Emergency Management Agency, or from your base disaster preparedness personnel. Being prepared is your best defense when a hurricane strikes your area. Using common sense and obeying the guidance given by the local authorities will go a long way toward ensuring your safety.

PRM: Your Ticket to Safety

By Mr. Patrick J. Spoor, Cannon AFB, N.M.

Personal Risk Management (PRM) is a common sense way of accomplishing a task with reduced risk.

It is a systematic process to help all individuals make sound decisions in a logical manner. It is a method of getting the task done by identifying areas that present the highest risk and taking action to eliminate, reduce or control the risk.

The principles of PRM are based on the Operational Risk Management concept, but it focuses more on human factors. PRM can be used to plan a long distance trip or something as simple as a bicycle ride from the base to town.

Like ORM, the first thing is to identify the risk. Visualize the expected flow of events and identify any conditions, which might result in injury, death or property damage. Then assess the risk, determine which of the identified hazards present the greatest risk, considering the potential outcomes and their probability and severity.

Next analyze control measures, determine what controls can be implemented to counter the assessed risks.

The last step is to make control decisions. Determine which courses of action will best accomplish the task with an acceptable level of risk.

Remember, PRM is a process of thinking through a task before you act. Ask yourself, do the benefits outweigh the risk. If you need more information, call your wing safety office.



AADD Airman Receives “O” Flight

By SrA. Timothy C. Jenkins, Ellsworth AFB, S.D.

A volunteer for the base's Airmen Against Drunk Driving (AADD) program was recently rewarded for all his hard work in the AADD program. A1C. Curtis Hanson, 28th Maintenance Squadron aircraft systems fuels apprentice, received an incentive ride on the HH-60 Blackhawk helicopter June 1, by members of the South Dakota Army National Guard. Hanson's ride included a flight over the Black Hills and a brief stop high above the Mount Rushmore National Memorial.



The thoroughness of the risk assessment depends on time available, the expected gains, and the associated hazards among other variables.

One of the great strengths of the ORM program in the Air Force is its inherent flexibility as the depth of the risk assessment can be tailored to the specific scenario it is being used for.

The flexibility and utility of this tool also make it a viable process for off-duty situations.

Camping trips, Labor Day weekend plans, and family vacations are only a few examples of scenarios that would be greatly enhanced by the proper application of risk management.

For more information on ORM, talk to your Commander.

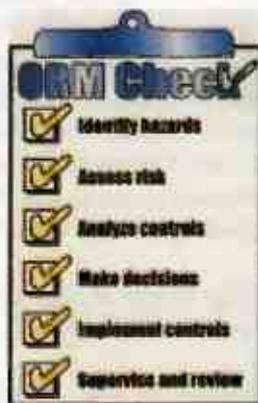
ORM: Not Just for the Flightline

By Capt. Scott Foster, Pope AFB, N.C.

Over the past few years the Air Force has worked to integrate Operational Risk Management into daily operations. The purpose of the integration is to create a more proactive environment in which problems are prevented in the planning phase.

Risk management is practiced with intent of minimizing risk while maximizing benefits, rather than reacting to close calls or mishaps as we have in the past.

The formalization of the ORM program varies greatly across the Air Force. In some units, risk management is used on a daily basis and in other cases, the tool is only used periodically. Both approaches can be correct for their situation.



Think Safety First



This car was driven by a military member who was test driving a friend's car after a promotion party. The driver was intoxicated and traveling very fast on a dirt road. The driver was not wearing a seat belt, and was thrown from the car and killed. Two passengers were wearing seat belts and walked away. (Photo by 55th Wing Safety Office, Offutt AFB, Neb.)

**Arrive Alive
Don't Drink & Drive**

Soft Bedding a Factor in Playpen Deaths

WASHINGTON, D.C — The U.S. Consumer Product Safety Commission (CPSC) released a report in July on deaths in playpens. Since 1988, CPSC has reports of more than 200 babies who died while in playpens. In almost 100 of these deaths, soft bedding or improper or extra mattresses were present in the playpen and the babies died of suffocation or Sudden Infant Death Syndrome (SIDS). More than 70 percent of these deaths were to babies less than 12 months old. Twenty-six of the playpen deaths occurred in a daycare setting.

Over the years, playpens, portable cribs and play yards have evolved into virtually identical products. Parents use playpens today as places for babies to both sleep and play. To educate caregivers, CPSC and Mattel, Inc. are launching a "Sleep Safe, Play Safe" campaign to address the two greatest hazards revealed by the study: 1) adding soft bedding and 2) adding extra mattresses or cushions.

For years, CPSC has warned about the dangers of soft bedding such as quilts, comforters and pillows in cribs. Soft bedding can become molded around an infant's face and cause suffocation. As many as one-third of baby deaths attributed to SIDS, in fact, may be suffocation in soft bedding.

"Many parents and caregivers know the dangers of soft bedding in cribs," said CPSC Chairman Ann Brown. "This study shows, for the first time, that the same dangers exist when using pillows, quilts and comforters in playpens."

The findings emphasize the need for caregivers to be aware that the same safe sleeping guidelines that they follow for their babies' cribs should be followed in these playpens. That means placing baby on his back on a firm, flat mattress and not adding extra mattresses or any soft bedding, such as pillows, quilts or comforters.

"At Mattel, the well being of children is an inherent part of the reason for our organization to exist and we reflect this in all that we do," said Jim Walter, vice president of corporate product integrity for Mattel. "We are happy to be working with the CPSC on the 'Sleep Safe, Play Safe' campaign."

Other hazards identified in the study were playpens that were in poor condition, had broken or protruding hardware or had side rails that collapsed creating an entrapment hazard.

To prevent deaths or injuries to children in playpens, parents and caregivers should take these precautions:

- Before using a playpen, make sure it has not been recalled. Contact CPSC at 1-800-638-2772 or check the recalls section of CPSC's web site.
- Always put a baby down to sleep on his back in a playpen or crib with no soft bedding, such as quilts, comforters and pillows. This can help reduce the risk of SIDS and prevent suffocation.
- Use only the mattress provided by the manufacturer. Do not add additional mattresses in playpens. Children can suffocate in the spaces formed between mattresses or from ill-fitting mattresses.
- Check that the playpen is in good shape. Using a modified or improperly repaired unit can create hazards.
- Make sure the top rails of the units lock into place automatically. More than 1 million older playpens with top rails that had to be manually rotated into a locked position have been recalled.
- Do not use playpens with catch points, such as protruding hardware. More than 9 million older units with protruding hardware have been recalled.
- If using a mesh-sided playpen, make sure the mesh is less than 1/4 inch in size and that it is attached securely. This will help prevent strangulation.

For more information on playpen safety, visit the publications section (Children's Furniture) of CPSC's web site at www.cpsc.gov or call (1-800) 638-2772.



Letters From the Field

In the July issue of *The Combat Edge*, I enjoyed the articles on PPE, Following Tech Data, etc...

However, I feel compelled to point out an error. Pages 28 & 29 contain photos of SrA Miller performing the task of safety wiring; however, although the article specifically pertains to ORM, he is NOT WEARING eye protection in either photo. Last I recall, the Tech Order states that eye protection MUST be worn. Maybe this was a test? A test to see if those of us in the field would spot it? Just wanted to point out, that we technicians in the field are looking closely, with "Eagle eyes".

SSgt Curtis R. Chism
Aviano AB, Italy

Thanks for the e-mail. Your're right! Our mistake. Good catch! — The Combat Edge



Pilot Safety Award of Distinction

Capt. Lendy Renegar was participating in a Phase II operational readiness exercise as number three of a 4-ship, night, aircrew coordination training sortie. En route to the airspace, Renegar noticed that he was having trouble breathing and his eyes had a burning sensation. The interior lights were set at low intensity so he was unable to see the smoke that was filling the cockpit. Upon sensing the hazard, Renegar immediately selected 100 percent oxygen and emergency pressure on his oxygen regulator, declared an emergency and turned his aircraft towards the landing field. At this point, he was able to turn on a hand-held light and found that the entire cockpit was filled with smoke. Renegar began an emergency descent from flight level 220 to below 18,000 feet and continued with the next step of the smoke and fumes checklist. He turned and pulled the cabin pressurization handle, which caused the smoke in the cock-

pit to dissipate, stopping his eyes from burning. Renegar began to scan the cockpit for the source of the smoke and fumes, but was unable to locate it. He began to dump fuel for the emergency recovery and landed the aircraft via a straight-in instrument landing system approach. Once on the ground, he stopped straight ahead on the runway and emergency ground egressed. Post-flight analysis of the aircraft found that a formation light transformer rectifier, located in the cockpit, had failed in flight and had begun to smolder, producing toxic smoke and fumes. Capt. Renegar's quick analysis of the smoke and fumes without the use of visual cues allowed him to expertly execute the appropriate checklists and safely recover the aircraft.



Capt. Lendy G. Renegar,
58th Fighter Squadron,
33rd Fighter Wing,
Eglin AFB, Fla.

Unit Safety Award of Distinction

On April 4, 2001, the Tower, Radar Approach Control (RAPCON) and Airfield Management (AM), which comprise the 4th Operations Support Squadron's Airfield Operations Flight at Seymour Johnson AFB, North Carolina, joined forces to avert potential disaster for a crippled F-15E. The fighter, call sign Jester 32, caught fire after massive bird strikes to the fuselage and engines occurred during low-level training. Upon notification, RAPCON swiftly initiated emergency action procedures clearing the approach corridor, alerting the appropriate agencies and assuring Jester 32 did not fly over populated areas. RAPCON then coordinated with adjacent air traffic control (ATC) facilities to obtain special use airspace, which could accommodate 17 airborne F-15E aircraft in a holding pattern. Meanwhile, Seymour Johnson's tower controllers

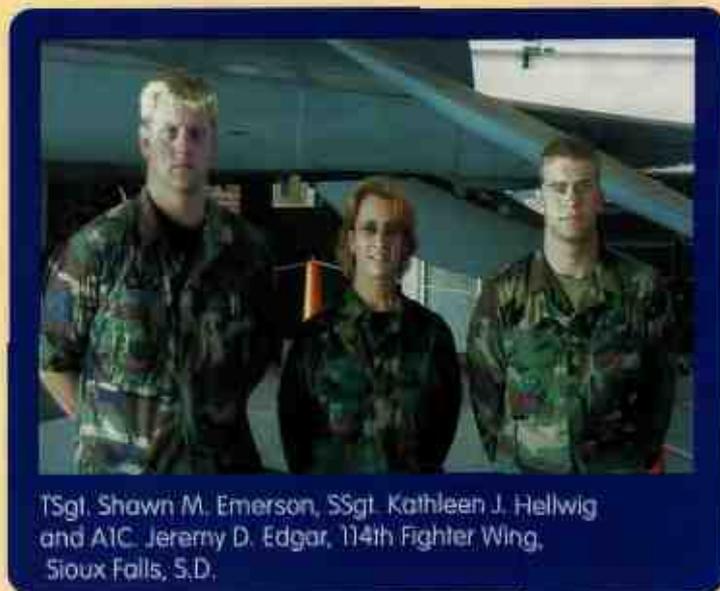


activated the primary crash phone to notify the appropriate base agencies and plotted emergency response team locations on the airfield. The AM team activated the secondary crash phone informing 14 additional base agencies, then dispersed selected members to strategic locations on the airfield to ensure that all 11,758 feet of runway were cleared of all debris. The remaining AM crew kept senior leadership updated and disseminated Notice to Airmen advisories to inform other aircrews of potential airfield closure. Tower and RAPCON coordinators collaborated to recover four F-15Es ahead of Jester 32's anticipated arrival. ATC coordinators then cleared Jester 32 for an opposite direction approach. Once Jester 32 landed safely, the Crash Team battled the aircraft fire supplied by over 4,000 pounds of fuel still in the tanks. Simultaneously, ATC coordinators formulated 17 separate flight plans for the aircraft that remained airborne in a holding pattern. When these aircraft reached divert-fuel status, RAPCON quickly coordinated the incoming flights with Cherry Point Approach and all 17 aircraft landed without incident.

Flightline Safety Award of Distinction

On April 26, 2001, TSgt. Shawn Emerson, SSgt. Kathleen Hellwig and A1C. Jeremy Edgar prepared an F-16C for a dry motor run on the flightline at Joe Foss Field, S.D. Emerson was in the cockpit; Edgar was on the ground communication headset and Hellwig was the fireguard. Two minutes into the dry motor operation, leaking fuel ignited in the engine bay and flames appeared along the keel beam of the aircraft. Edgar immediately told Emerson to cease the operation. Hellwig acted at the same instant to charge the Halon fire bottle. She removed the hose from the holder, activated the nozzle and doused the flames with the suppressant. Edgar then took the extinguisher nozzle and proceeded to discharge Halon into the aircraft fire door, snuffing out the burning fuel inside the engine bay of the vulnerable fighter. While the fire was being extinguished, Emerson shut down the cockpit switches and provided guidance to Edgar through their ground com-

munication connection. Emerson safely egressed the damaged aircraft as his two coworkers inspected the engine bay to ensure the fire was out. The immediate and decisive actions of TSgt. Emerson, SSgt. Hellwig and A1C. Edgar prevented catastrophic damage to a multi-million dollar fighter and possible loss of life.

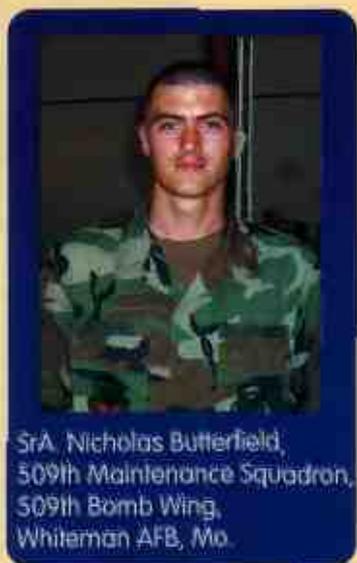


TSgt. Shawn M. Emerson, SSgt. Kathleen J. Hellwig and A1C. Jeremy D. Edgar, 114th Fighter Wing, Sioux Falls, S.D.

Ground Safety Award of Distinction

While escorting a civilian contractor who was doing routine maintenance on an underground sewer service pipe, SrA. Nicholas Butterfield noticed decreased movement in the contractor's safety lifeline and the presence of a strong chemical odor. Quickly assessing the situation, Butterfield determined the contractor was incapacitated and required immediate assistance so he promptly alerted the other contractors. Without hesitation, he employed the assistance of two individuals and started the emergency extraction of the downed, non-responsive contractor.

After the contractor was safely removed from the service pipe, Butterfield immediately notified all appropriate emergency response agencies allowing the contractor to receive much needed, on-the-spot medical care. The contractor was then transported to a local hospital for further medical treatment. The decisive and professional actions of SrA. Nicholas Butterfield prevented certain loss of life.



SrA. Nicholas Butterfield, 509th Maintenance Squadron, 509th Bomb Wing, Whiteman AFB, Mo.

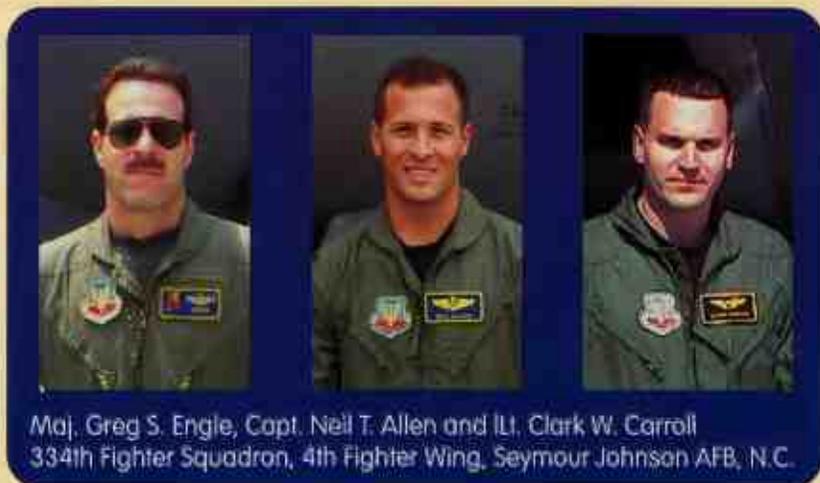
ACC is proud of our Monthly safety honorees



Aircrew Safety Award of Distinction

On April 4, 2001, 1Lt. Clark Carroll, upgrading pilot, and Capt. Neil Allen, instructor weapons system officer, launched out of Seymour Johnson AFB, North Carolina, as the number two F-15E of a two-ship, night, surface attack, tactics sortie. Their flight lead was Maj. Greg Engle. The sortie proceeded as planned through take-off, departure and entry into a Low-Altitude Navigation and Targeting Infrared for Night (LANTIRN) en route to the Dare County Bombing Range. While flying at approximately 500 feet and 500 knots on terrain-following radar 4 miles in trail of Engle, Carroll and Allen suddenly felt and heard a loud bang. Immediately, the number two engine firelight illuminated and had a bleed air light, smoke began filling the cockpit and there were substantial airframe vibrations, which indicated problems with the number one engine. They initiated a climb to safe altitude and turned toward their home base. They called for a "Knock-It-Off," informed Engle of their situation and requested his assistance as chase ship. Carroll shut down the number two engine and completed the checklist for an in-flight engine fire. Engle then rejoined and informed Carroll and Allen that a plume of fire and

sparks was still streaming out the back of the number two engine. Engle suggested an opposite direction landing to save valuable time and coordinated that with the Supervisor of Flying. Carroll and Allen elected not to dump fuel, executed a flawless single-engine approach and landing and conducted an emergency ground egress. Post flight inspection revealed extensive damage to the aircraft caused by multiple bird strikes to the engines, engine intakes, radome, LANTIRN pod and windscreen. Quick thinking, outstanding airmanship and appropriate actions by Maj. Engle, Capt.



Maj. Greg S. Engle, Capt. Neil T. Allen and 1Lt. Clark W. Carroll
334th Fighter Squadron, 4th Fighter Wing, Seymour Johnson AFB, N.C.

Allen and 1Lt. Carroll contributed to the safe recovery of the aircrew and a valuable Air Force asset.

ACC Safety is Proud of All Our Award Nominees

Mr. Gary Orton
Engine Operator
Mr. Vernon Axe
Ground Observer/Fire Guard
9 RW
Beale AFB, Calif.

SSgt Michael S. McCarthy
Logistics Group Quality
Assurance Inspector
509 LG, 509 BW
Whiteman AFB, Mo.

MSgt Robert T. Bailey
Flight Line Expediter
93 AGS, 93 ACW
Robins AFB, Ga.

SSgt Mark A. Baughman
Tropospheric Satellite
Support Radio Crew Chief
31 CCS, 3 CCG
Tinker AFB, Okla.

SSgt Michael J. Brien
NCOIC Power Production
52 CCS, 52 CCG
Robins AFB, Ga.



Go through the proper channels to submit your Safety Achievers for awards! Point of Contact is Ms. Barbara Taylor, DSN 574-8846, Commercial (757) 764-8846, fax 8975; e-mail: barbara.taylor@langley.af.mil.

It Only Takes a Second

By TSgt. Matthew Gadziala, Nellis

AFB, Nev .

I have a 5-year-old son and a 16-month-old toddler. Both children are beautiful and healthy, and I consider myself to be a good father. All of that almost changed one day because of a moment of complacency.

I was playing "Mr. Mom" while my wife was at work. The day started out just like any other. The kids got up at the crack of dawn. We had breakfast. We played. We had lunch. We played. We had dinner. Finally, it was bath time. Relief was in sight!

My son and daughter were in the tub together. The bubbles were going and the tub was filled with their favorite toys. I joined in the playful splashing while the tub filled with water. Then I snuck out — only for a minute — to get their pajamas ready. I was only halfway down the hall when my son loudly screamed "Daddy!" I tore down the hall back towards the bathroom as

my worst fear melted into the reality before me. I could only see one child in the tub; my daughter had slipped under the water. I immediately pulled my submerged daughter from the water. She came up choking and crying as I whispered a prayer of thanks. Within a minute she returned to normal as if nothing had happened. I stayed with my children for the remainder of the bath and they made it safely to their beds without any other incidents.

After tucking the kids in, I reflected on our close call. I was frightened by how fast it had all happened. I know I was not out of the bathroom for more than a minute. But it was just a few seconds that made a world of difference between what actually happened and what might have happened.

I know a lot of parents have similar stories; a child either falls down or gets into cleaning

supplies by accident. These experiences are what help us realize just how close tragedy lurks, but there is a way to minimize the frequency of such incidents.

Ninety percent of all accidents at home can be avoided with just a few simple precautions. First and foremost, we must stay vigilant in all environments and avoid complacency in our routines. It was my complacency that almost turned my world upside down. Second, we have to childproof our homes. Simple steps such as putting dangerous chemicals up high and covering all electrical outlets with plastic plugs go far to create a safe environment. Remember, implementing safety precautions is well worth the investment of time and money because "it only takes a second" to realize the high price that will be paid by our children if we do not.

For these and additional tips on making your home a safe place, visit www.safebaby.net. ►



Photo by TSgt. Jack Braden



OK, it's no secret that rodeo is an inherently dangerous activity. It says so in darn near every rodeo document ever produced. So believe it, because it's true.

Being members of the military we all should know about risk management and risk assessment. We also know that each and every person is responsible for their own safety

and the safety of others. This type of knowledge also applies to rodeo activities.

Let's focus our attention on one of the most dangerous events at the rodeo: bull riding. Bull riding in itself is a very safe event. As long as you stay in the right position at every moment during the ride, the only dangerous part is in the chute and dismounting. Unfortunately, no rider makes the per-

fect ride every time or even most of the time. The hanging up, the getting hooked, the getting stomped, the getting thrown, the landing and the sheer physics of the deal itself make this a reality. The bull is bigger and stronger than you, and the bull will win in any physical contact match up.

So how do we stay safe and healthy when we dance with disaster? That's easy. We uti-



Safety's No Bull

By Mr. Don Hadley, Professional Armed Forces Rodeo Association

Photo by SrA. Jeffrey Allen

lize safety procedures all the time. It starts before you get in the chutes, and it ends after you exit the arena. I'll break it down into categories that will allow you to work on each aspect of it separately.

PREPARING TO RIDE: Check your gear. Make sure everything works properly and is fully functional. Your protective vest should be serviceable and your mouthpiece and gloves

should be in good condition. Worn out bull ropes roll over real easy and can lead to hang-ups. Hopefully, you are already in good physical shape. Make sure you stretch well and get your muscles warmed up.

CHUTE PROCEDURES: Once your bull is identified and loaded in the bucking chute, it's your bull. Make sure you have a spotter to help you out. Climb the chute. Place your outside leg (the one farthest from the arena) on the bull's back. Let him know you are there and you intend to ride him. Reach the

top rail with your inside hand (the one closest to the arena). Swing your other leg over and kneel on the bull (your spotter should have his hand on your chest to help pull you out in case things get bad). Drop both legs into the chute to a comfortable position. Make sure you have just the outside of your foot (not your toes) on the chute gate. This will protect your ankle from being broken and allow you to jimmy backwards and forwards with the bull. Drop your rope and adjust the length as needed.

BEFORE YOU CALL THE GATE: Put your glove on your hand and take your rope. Reach forward on the top rail of the chute gate with your free hand. Slide up on your rope and get your feet near the rope. Do not grab hold with your spurs because the bull will generally start bucking. Make sure the bull is looking toward the arena and call your gate. Keep your free hand on the chute or gate until it naturally releases as the bull turns out.

DURING THE RIDE: Know when your ride is over. Many new guys are more concerned about making a qualified ride than the next rodeo. There comes a time in bull riding when you are beat, and you should learn when that time is. We are not talking about quitting or giving up. We are talking LONG-TERM SURVIVAL. This happens when you get out of position and no correction can get you back to home base. You have slid down into the inside of the bull's spin (the well) or to the outside, and you are looking at the bull's kneecaps. Your ride is over — you need to let go and get out of the arena. You can find this point of no return by practicing on a barrel. Gravity will not lie or cheat you, but it will let you know where this point of no return is. You will not see anyone in the Professional Bull Riders (PBR) picking up any points by riding under a bull, because the points will not be there. Besides they want to be able to compete at the next event. When you are beat, be a man, admit it, get to the nearest fence and make the next go-round.

HANG-UPS: Nobody has fun in the hang-up. Sure they are fun to watch on TV, like "The

World's Most Dangerous Stunts," but that's it. If you find yourself hung-up, it is your responsibility to free yourself, not the bullfighters. They will help by straightening out the bull, and, yes, they will come in for you if you get knocked out. But it's your bull, deal with it. First, get to your feet. Bad stuff happens under a bull — you are safer beside it. Second, open your hand. I know it sounds easy, but the last command you gave your hand was to hang on like your life depended on it. Most hands will do just that. If you open your hand, you will probably fall free. Third, if your hand is open and you are on your feet, but you are still hung up, get your riding hand elbow on the other side of the bull's spine. Your hand will come out. Do not try to pull your tail. You will probably pull it the wrong way, tightening it instead of freeing yourself. Finally, get to the nearest fence and climb up and over it.

DISMOUNTING: Always get off a moving bull on your riding hand side. You made your ride and the whistle sounds. Let the bull-



Photo by SrA. Jeffrey Allen



fighters straighten your bull if he is spinning into your hand. Free your hand, glance over your riding shoulder and pick a spot. Thrust your free arm over your head, let go with your riding hand and inertia will clear you from the bull,

get to the nearest fence, UP AND OVER. Never get off a stopped bull. Spur him to make him move or wait for the bullfighters to make him move, then dismount normally. Never get off on a fence or panel, you are only asking

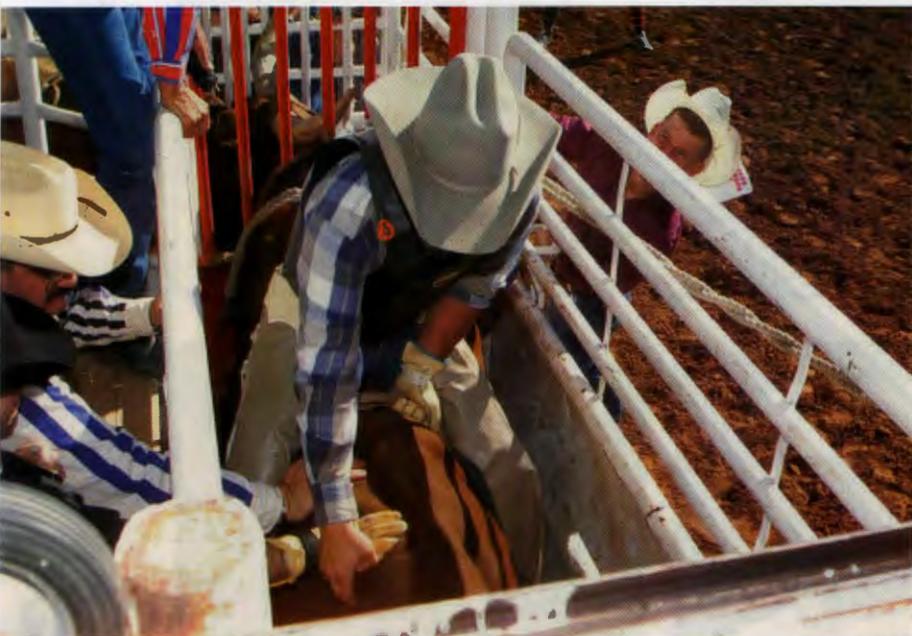
nal cord — trust me on this one. When your ride is over and you are separated from the bull, get up, run to the nearest fence and climb up and over it. You can throw your hat and wave to your millions of fans when you retrieve your bull rope and thank the bullfighter. Get out of the arena while the bull is still there.

INJURIES: If you do sustain an injury, try to get up and out if you can. Adrenaline can really help at this moment. When you are safe, feel free to collapse. Try to stay calm and let the medical personnel help you. I know we are all in the military and it does not help when your buddy says you're OK and you know something is really wrong. Stay calm until the medical folk arrive — they earn more and are better trained than your buddy.

PROTECTIVE GEAR: Nothing can keep you from getting injured ... but riding vests are mandatory. There are many types and styles out there. Do a little research. Helmets — I like them, but, no, they will not keep your brain intact if a 2,000-pound bull lands directly on it. They will, however, cut way back on concussions from head butts, horns and ground impacts. Running around with missing teeth is not cool — seriously.

Many commanders and supervisors have been more than fair in letting military members participate in the rodeo arena. Do not forget to thank them for letting you compete. And always remember that safety is a primary concern and a risk management program is essential to your rodeo success. ►

NOTE: For more information about the Armed Forces Rodeo Association and safety techniques search <http://www.homestead.com/pafra/>



for trouble. They, much like the bull, are tougher than you.

LANDING: If you find yourself accelerating towards the dirt, ball up and go with it — you will save ankles, knees and wrists. Once on the ground, try to maintain a cushion of air between your body and the ground. Crawl till you can run. If the bull hits you while you are on your hands and knees, you can absorb more of a hit than if you are flat on the ground. A dislocated shoulder beats a severed spi-

Fleagle



Weapons Notes

Overall, mishap rates are down from the same reporting period for the previous fiscal year.

Personnel error is the leading cause of this year's events. Within this category, mishaps have occurred because personnel have not followed approved tech data or have performed improper procedures. Supervisors and managers should take note and increase their vigilance of these factors. Weapons Safety and Quality Assurance inspectors should consider forming combined teams to review operations.

Flight Notes

Numerous flight safety records were set last year, but one-third of ACC's Class A flight mishaps occurred in the last 2 months of the fiscal year (August and September). We have less than 1 month to go in this flying year so review COMACC's "Adverse Trends In Flight Safety" message (23 Jul 01) and let's all close out this year's flying hours smartly and safely.

Flight

As of July 27, 2001

8 AF	
9 AF	
12 AF	
AWFC	
ANG	
AFR	
Aircrew Fatalities	

Ground

As of July 27, 2001

	Class A	Class B	Class C	Fatalities
8 AF	0/0	0/0	112/\$859,281	0/0
9 AF	3/\$403,412	0/0	112/\$490,088	3/\$403,412
12 AF	7/\$1,850,120	1/\$115,000	177/\$781,423	6/\$750,120
DRU	3/\$1,125,000	0/0	36/\$181,095	1/\$125,000
FY 01 Totals	13/\$2,278,532	1/\$115,000	437/\$2,311,827	10/\$1,278,532
FY 00 Totals	177/\$875,765,435,011	3/\$529,660	575/\$2,718,527	15/\$2,934,170

Weapons

As of July 27, 2001

	Class A	Class B	Class C	Fatalities
8 AF	None	None	3	None
9 AF	None	None	1	None
12 AF	None	None	1	None
AWFC	None	1	None	None
Total	None	1	5	None

Class A - Fatality; Permanent Total Disability; Property Damage \$1,000,000 or more
 Class B - Permanent Partial Disability; Property Damage between \$200,000 and \$1,000,000
 Class C - Lost Workday; Property Damage between \$20,000 and \$200,000

Ground Notes

Since ACC's stand-up:

- 222 people have lost their lives due to ground mishaps.
- Another 20 have become permanently disabled.

Five units have never had a fatal mishap:

- 65 ABW, Lajes AFB, Spain
- 85 GP, Keflavic NAS, Iceland
- 93 ACW, Robins AFB, Ga.
- 819 RHS, Malmstrom AFB, Mont.
- 820 RHS, Nellis AFB, Nev.

Unit that has gone the longest without a fatal mishap:

- 23 FG, Pope AFB, N.C. (Sept 4, 1995).

Latest fatal mishap:

- 366 WG, Mt. Home AFB, Idaho (July 7, 2001).

Major factors of fatal mishaps:

- 9 of the 10 fatalities involved lack of PPE (seat belts, helmets and/or the use of alcohol).
- 10th fatality was an industrial mishap in which lack of PPE was a contributing factor.

Off-duty mishaps account for 70 percent of all ACC mishaps (317/453):

- Sports and recreation account for 32 percent (144).
- Private vehicles account for 26 percent (117).

Motor vehicle (both GMVs and PMVs) mishaps facts:

Participants in 24 of 129 motor vehicle mishaps were either intoxicated and/or failed to use PPE like seat belts or helmets.

Lock on Safety

A1C. Adriane Bean, foreground, Weapons Load Crew Member for the 71st Fighter Squadron, Langley Air Force Base, Va., checks for error readings while A1C. William Massey pulls the trigger during Gun System Operational Check. The training conducted at Langley's Maintenance University trains weapons loaders to operate equipment safely.



Photos by TSgt. Jack Braden

The Combat
EDGE

