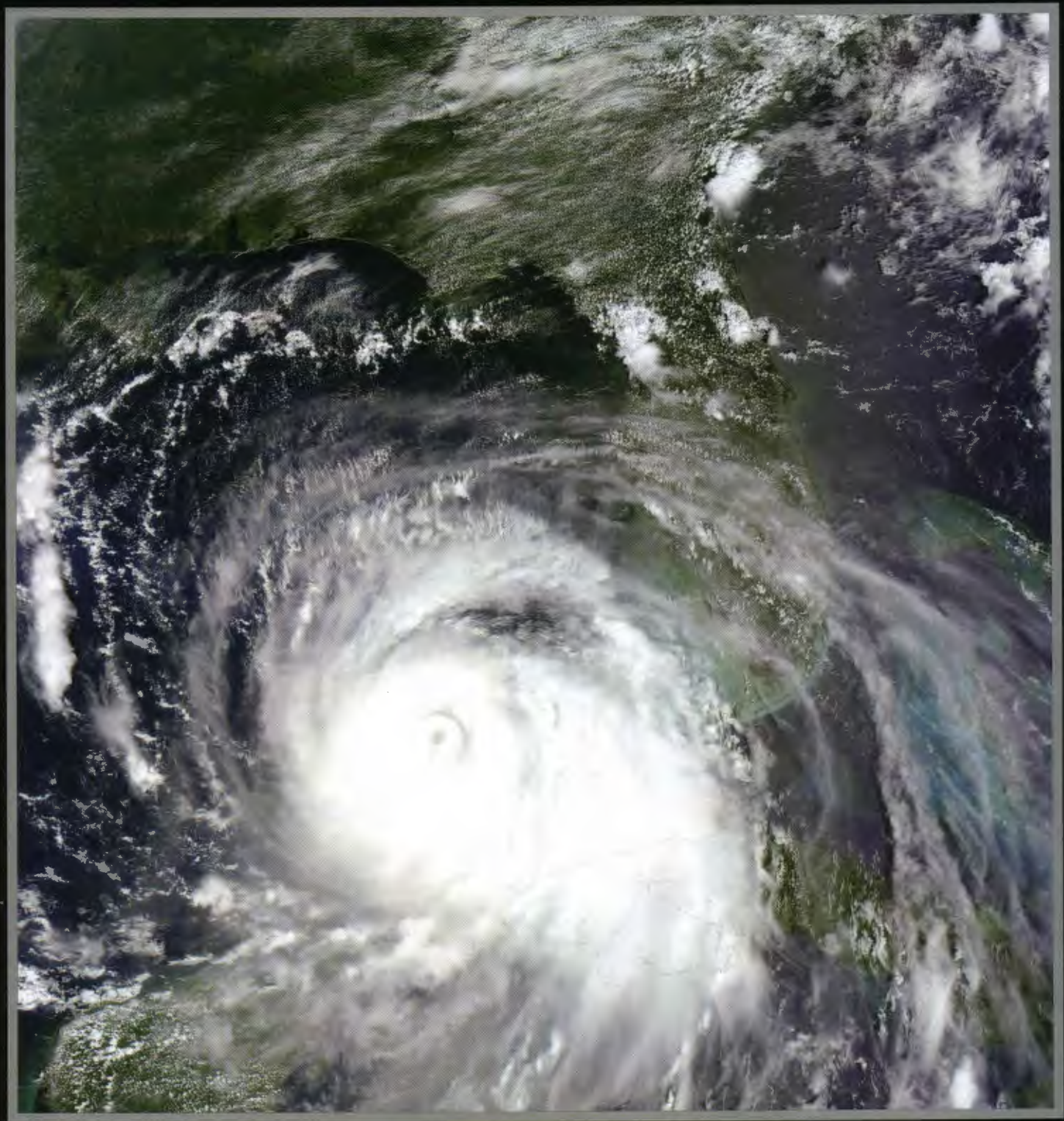
Combat Edge

June 2006



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Combat Edge

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ACCent on Safety

Focus On Being a Good Wingman This Summer

Stating the obvious, people are Air Combat Command's number one priority. It also goes without saying that preventing mishaps, suicides, and other self-destructive behaviors are directly tied to this priority. Time and time again, commanders and supervisors at every level have focused on mishap/suicide prevention. Perhaps it is time to focus on what it means to be a good wingman.

There are many efforts within the command to raise awareness when it comes to safety and suicide prevention. Events/campaigns like Wellness Days, Safety Days, and the Air Force's 101 Critical Days of Summer provide a wealth of knowledge you can add to your personal toolkit to be a good wingman. So one key duty of being a good wingman is to know what tools are out there to help you. In the past, ACC has set aside a single day for the command to hold a "Wellness" or "Wingman Day," however, there is no reason why individual bases, squadrons, or units cannot take an afternoon to turn the focus inward on the health of the unit and its members. Another duty of being a good wingman is accepting that it is a 24/7/365 responsibility. A good wingman doesn't take time off or is selective when it comes to safety or suicide prevention.

Look to the centerfold of this issue to read our Chief's views on how each of us can work to spot a potential disaster, and how we can help prevent one. The Air Force Suicide Prevention Program (AFSPP) was established to focus on our core value that every Airman is a wingman and responsible for taking care of each other. To prevent mishaps, a good wingman takes **action** — the key ingredient of being a good wingman. This is easier said than done, but action requires individual courage to step in and ensure our wingman is doing the right thing.

Remember: being a good wingman takes work … it takes knowing what programs you can draw on for knowledge, it is a 'life-long' duty, and it takes courage to step up to make a difference. Being a good wingman does save lives and does help us maintain our ***Combat Edge!***

Colonel Creid K. Johnson,
ACC Director of Safety

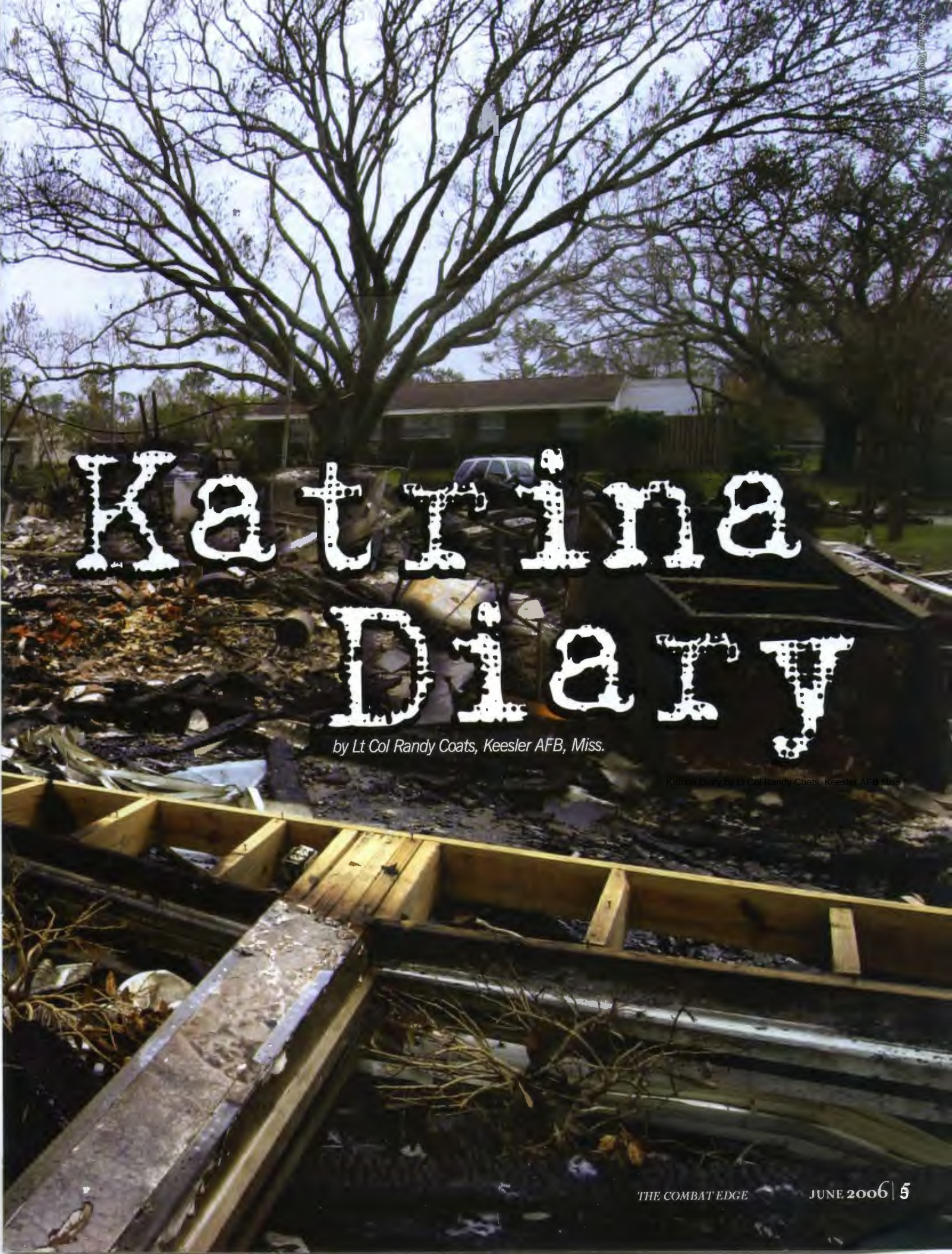
Command -- there's no better job in the world. After 7 years in jobs with "command authority" and two squadron commands, I figured I had a good idea what command was all about. I was wrong. What changed my mind? Four words: "Shelter Commander" and "Hurricane Katrina."

From August 28 to September 2, 2005, I lived with 730 of my "closest friends" in 50-year-old Bryan Hall at Keesler Air Force Base, Miss. It was my third stint as a shelter commander, but it was unlike anything I had experienced before. As life slowly returns to normal on the Gulf Coast, and I reflect on the experience, I've come to appreciate the unpredictably of command and how much an event like Katrina can change people and communities.

First, you have to understand some basics. My shelter is a unique animal on Keesler. Most shelters here are dedicated primarily to one unit. Mine is not. I have all the active duty and family members from a wide variety of units: two training squadrons; Civil Engineers (CE); and Security Forces (SF) and their prisoners; 100-plus Marines; communications students, including Noncommissioned Officers (NCOs) and roughly 60 Lieutenants; 150 NCO Academy students and their faculty; and 50 international officers and their families. The building is an old nuclear fallout shelter, with no windows and no shower facilities. With that setting in mind, I offer the following memories and thoughts on Hurricane Katrina.

August 25th (Thursday): One of my sharp young Master Sergeants points out Katrina "may grow into something over the weekend" and suggests we update our shelter/evacuation data sheets. I admire his enthusiasm, tell him "that's not a bad idea," and then promptly forget to do anything. After all, Katrina's not headed our way, and I've got other things to do besides worry about a piddly Category 1 storm.

August 27th (Saturday): Two Crisis Action Team (CAT) meetings. Katrina has strengthened and is headed our way, due to arrive Monday afternoon. Tentatively plan to open shelters Monday morning. I remember the



Katrina Diary

by Lt Col Randy Coats, Keesler AFB, Miss.

Katrina Diary by Lt Col Randy Coats, Keesler AFB Miss

MSgt's words and begin repeating every officer's golden rule: "Never ignore a senior NCO ... Never ignore a senior NCO."

August 28th (Sunday): Turn on CNN before heading to 8:00 a.m. CAT meeting. Radar pictures show Katrina as a Category 5, taking up the whole Gulf of Mexico and headed straight for us. It was due to arrive before dawn Monday. "Never ignore a senior NCO ... Never ignore a senior NCO."

10:00 a.m.: Initiate full recall and order all personnel to evacuate or shelter no later than 9:00 p.m. Many people are out of town for the weekend. Accountability is a nightmare.

5:00 p.m.: Open the shelter. People and families begin arriving. Have to stop two refrigerators, one 21-inch TV set, and three mattresses at the door. Students (of all ranks) drafted to help carry bags into the shelter. People are told to bring food and water for 3 days. Most bring food for 2 days; smokers bring cigarettes for 20 days. Have to break the news: no smoking inside the shelter, and, once you're checked in, you can't go outside (Hotel California rules).

10:00 p.m.: Doors locked and boarded up from the outside by CE (one door in an alcove left uncovered).

August 29th (Monday):

5:00 a.m.: Winds howling; can hear them best through vents in bathrooms at the end of the hallway (it didn't sound like this during Hurricane Ivan).

8:00 a.m.: Shelterees (hereafter referred to as "the Natives") start moving around. Smokers are looking for a nicotine fix, but remain calm.

10:00 a.m.: Local news reports indicate rising waters and violent winds. Plywood ripped from external doorways (I start getting uneasy; plywood has never moved in previous storms, much less flown away).

12:00 p.m.: News reports 20-plus feet of water in the local mall. Natives are getting anxious. Smokers are getting jittery.

Afternoon:

• Power goes out; generators kick in. Not good. CE told us power can only go out if high-tension cables, that survived winds around 200 miles per hour during Hurricane Camille, go down. Air conditioning stops working; ventilation fans stop working. No windows, no open doors, 731 nervous people ... in Mississippi ... in August. Ask for generator fuel status and burn rate. Have enough fuel for 2 days.

• Natives who smoke are starting to visibly shake; many look physically ill.

• Cable TV goes out. Natives get creative with antennas; I spot the bottom half of an NCO sticking out from ceiling tiles. Apparently reception is better if you connect a stripped copper communication cable from the TV to pipes in the ceiling. I appoint a safety observer and hope for the best.

• CE reports primary generator has flames coming out of it, so shut it off. Internet connectivity is lost. Down to one generator; power only in hallways and a few rooms.

• Water stops running. Toilets are overflowing. With medical advice, I brief the Natives on how to use plastic bags for toilet facilities (someone used this method within 10 minutes). Disposal of plastic bags in a sealed building is a concern. Adventurous major goes into the basement and finds 1961-vintage Civil Defense Survival Sanitation Kits. Basically, a 3-foot tall cardboard

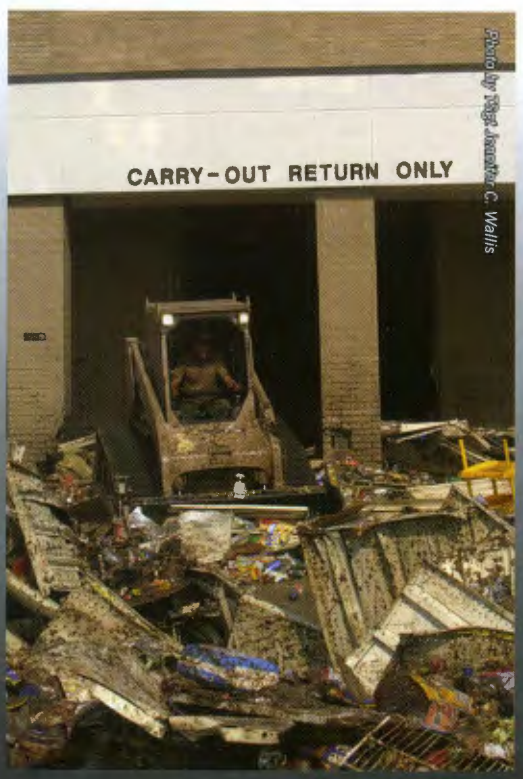


Photo by Sgt. Jonathan C. Wallis


Photo by Mr. Joe Piccorossi

port-o-potty with a hole cut in the top. This does not look fun; however, 44-year-old toilet paper (it was dated) is surprisingly soft.

• One hour later: Water comes back on thanks to CE heroes going out in the storm to repair the pumping station. I hug the first CE troop I can find. Thankfully, sanitation kits are not used, but kept on standby.

• CE troops coming off shift report half of the flight line is underwater; BX and Commissary are in water 6 feet deep and it's rising; trees are down all over the base; the CE building has collapsed. Natives begin to get the picture -- this is worse than either Hurricanes Ivan or Dennis.

Evening:

6:00 p.m.: Winds still dangerous so cannot open doors. It's hot ... it's humid ... Natives are getting cranky; smokers showing signs of extreme duress. One is carrying two unlit cigarettes around. I suggest he tear one open and put it behind his lip for a nicotine fix. He informs me he's already eaten an entire pack and it didn't help. I can't think of anything to say in response, so I pat him on the back and wish him luck.

• Babies and young kids getting grumpy; too hot to nap.

• Barely-visible news reports (on very fuzzy TV picture) report massive devastation in the area. Dead silence in hallway as Natives crowd around the lone TV with a discernible picture. Tension is rising.

8:00 p.m.: Too hot to breathe; 731 nervous people generate a lot of sweat and a variety of smells. Command Post says stay locked down so we don't open doors. Natives make strange noises when I walk by. Not sure the "Shelter Commander" badge is a good thing to be wearing right now. First Sergeant reports Natives consider me the embodiment of evil.

• Cops go on shift. The best NCO in the Air Force is assigned to patrol base housing; he offers to try to check on my cat during his shift (we left her in the hallway of my house).

9:00 p.m.: Even hotter. Poke my head outside; it's ugly, but winds have died down. Command Post says stay buttoned up. Natives are in small groups mumbling about how to eliminate a commander. Survival instincts tell me to get some air in here. Posted Marines at every exit and opened all the doors. I'm a hero; Natives love me. Haven't heard "thank you" this much since I put my shirt back on at the squadron pool party.

10:00 p.m.: Smokers running out of cigarettes to eat. Open a side door and rope off a 10-foot by 10-foot smoking area. No more than five people at a time; no more than 5 minutes at a time. Sucking cigarettes look like blow-torches in reverse; everyone loves me.

• Nobody sleeps much; tough to sleep in pools of sweat.

August 30th (Tuesday):

1:45 a.m.: One of my NCOs wakes me up because, "Cops want to talk to you, Sir." The SF senior NCO is direct. "The good news is your cat is fine." Next question was obvious as he hands back my house key and adds, "The bad news is I didn't need this to get into your house."

DISASTER SUPPLY KITS FOR THE HOME

Use sturdy, easy-to-carry containers like backpacks or duffle bags to store kit supplies. Portability is important should you have to move to higher ground at a moment's notice. Kits should be designed to sustain family members for a minimum of 3 days; however, as Hurricane Katrina demonstrated, supplies might have to last up to 1 or 2 weeks. It's also imperative that everyone knows where their designated shelters are located. BE PREPARED.

- Water (1 gallon per person per day)
- Food items (preferably high energy and non-perishable)
- Change of clothing and footwear per person
- First-aid kit (include prescription medications and mosquito repellant)
- Emergency tools (include hand saw and/or chain saw, sheet plastic)
- NOAA Weather Radio with warning alarm tone and battery backup
- Portable Radio
- Flashlights (one per person; avoid using candles or kerosene lamps)
- Extra batteries
- Extra set of car keys
- Credit cards and cash
- Cards, games, books
- Specialty items for infants, elderly, disabled, pets
- Waterproof container for important family documents
- Full tank of gas for each vehicle
- Know where your designated shelter areas are locally and your base's evacuation location (if applicable)

STRATEGIC PLAN

by Col John P. Good, Shaw AFB, S.C.

Don't you enjoy curling up by a fire, sitting under an elm in the spring, or sipping tea by the pool with a copy of Blue Four News? Do you reminisce about the days when you stood by the ops desk to read the latest mishap report? Does the thought of serving on an accident investigation board bring a smile to your face? If you grimaced or answered "no" to these questions, you're probably not alone. However, if you answered "yes" to any of these questions, perhaps that explains why you couldn't wait to read this article.

"NO" you retort? Well, is there an alternative to mishap investigations and reporting? Is there an alternative that requires less effort and stress? Of course! It's called strategic planning or, more simply, a targeted mishap prevention plan. Wouldn't we rather focus our attention on the simple things we can control that measurably reduce the chance of another mishap? Of course we would! But, what are these "simple things," and if they're so "simple," why aren't targeted mishap prevention plans common? Plausible explanations to this latter question are myriad. What you're probably wondering is how you can escape to this side of safety.

First, you need to define your mission in operational terms. That's right! An effective program starts with a clearly defined target, using simple but few words, characterized in a relevant manner. For example, let me suggest that the safety mission is to "enhance combat effectiveness (perhaps some prefer terms like "firepower" rather than "effectiveness") by the reduction of preventable mishaps." The challenge is the definition of terms like "preventable mishaps" and how to confirm your program trains attention on the right "simple things." For this article, I'll define a "preventable mishap" as any accident caused by the violation of official guidance (e.g., tech orders, policy, Air Force Instructions, law). A useful metric might be a sustained increase in sortie production, while quality assurance violations show a sustained downturn. Whatever you choose, clarity is a necessity. The adage, "you can't hit what you can't see" is certainly applicable when we seek to define a mission.

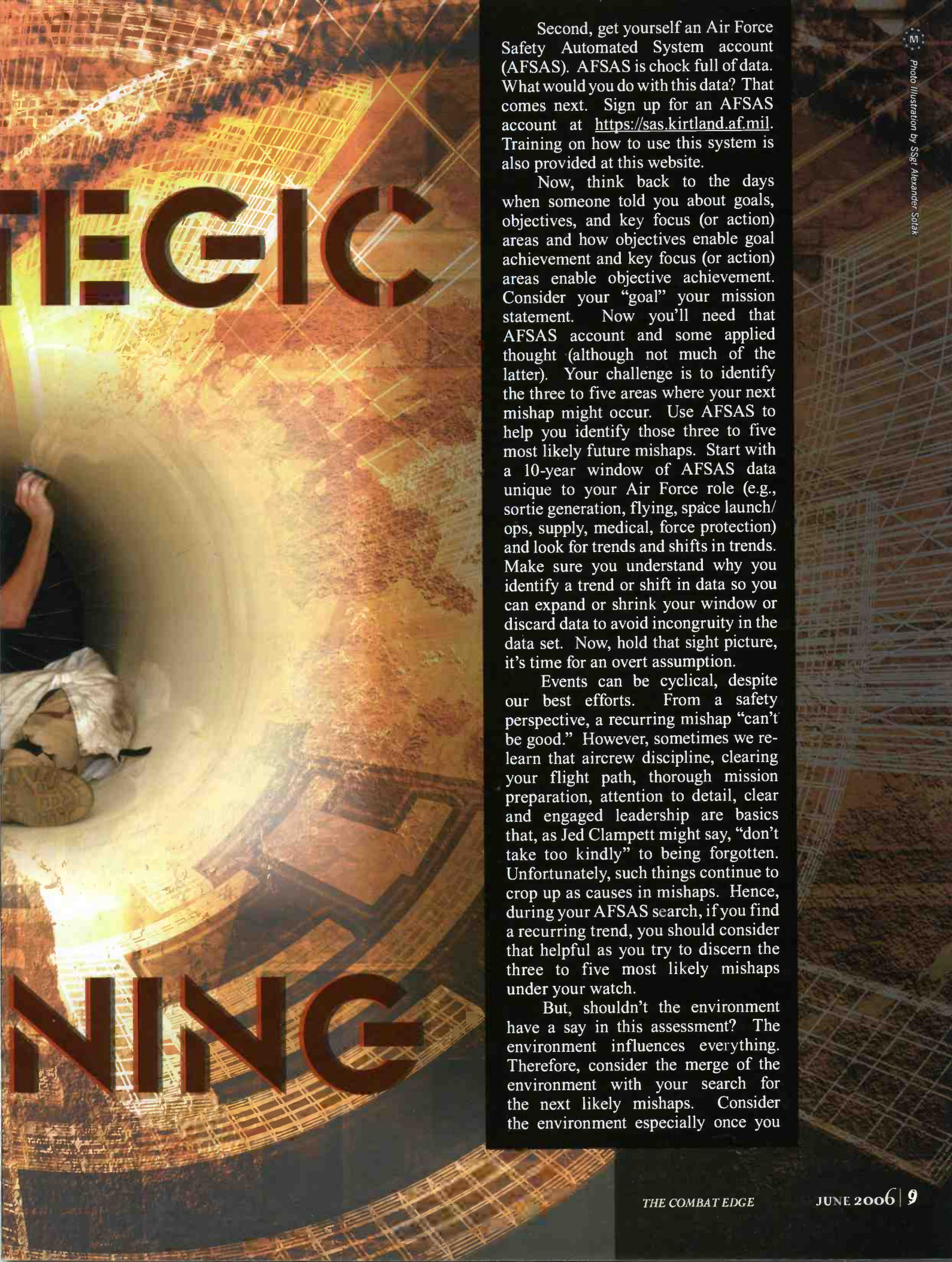


Photo Illustration by SSgt Alexander Sotak

Second, get yourself an Air Force Safety Automated System account (AFSAS). AFSAS is chock full of data. What would you do with this data? That comes next. Sign up for an AFSAS account at https://sas.kirtland.af.mil. Training on how to use this system is also provided at this website.

Now, think back to the days when someone told you about goals, objectives, and key focus (or action) areas and how objectives enable goal achievement and key focus (or action) areas enable objective achievement. Consider your "goal" your mission statement. Now you'll need that AFSAS account and some applied thought (although not much of the latter). Your challenge is to identify the three to five areas where your next mishap might occur. Use AFSAS to help you identify those three to five most likely future mishaps. Start with a 10-year window of AFSAS data unique to your Air Force role (e.g., sortie generation, flying, space launch/ops, supply, medical, force protection) and look for trends and shifts in trends. Make sure you understand why you identify a trend or shift in data so you can expand or shrink your window or discard data to avoid incongruity in the data set. Now, hold that sight picture, it's time for an overt assumption.

Events can be cyclical, despite our best efforts. From a safety perspective, a recurring mishap "can't be good." However, sometimes we re-learn that aircrew discipline, clearing your flight path, thorough mission preparation, attention to detail, clear and engaged leadership are basics that, as Jed Clampett might say, "don't take too kindly" to being forgotten. Unfortunately, such things continue to crop up as causes in mishaps. Hence, during your AFSAS search, if you find a recurring trend, you should consider that helpful as you try to discern the three to five most likely mishaps under your watch.

But, shouldn't the environment have a say in this assessment? The environment influences everything. Therefore, consider the merge of the environment with your search for the next likely mishaps. Consider the environment especially once you

Photo by SSgt David Donovan

Photo by SSgt Chad E. Chrisholm

implement your strategy. Changes in the environment, to include social influences such as holiday periods, will have differing effects, increasing the likelihood of certain mishap occurrences over others during those periods.

OK, so you have a goal (an operationalized safety mission statement) and objectives (i.e., three to five types of likely mishaps) now you're ready to go, right? Go where? Whoa! Hold on there! What are the things, those "simple things," that are key to reducing the occurrence of those three to five mishaps? Some of those things you probably know (e.g., adhere to tech order guidance, attention to detail, keep leadership informed). But, how do you apply these mantras and glean from a potential mishap area where to focus new attention? You'll find that each installation will be unique because of environmental factors, tools, and experience mix, so no one base with a similar mission will have the same focus areas or mishap potential areas as another base. However, each base will have about seven to eight key focus (or action) areas that have a cause-and-effect relationship with those three to five mishap areas that fit under the "SAM principle" (Simple, Actionable, Measurable). Perhaps one of these seven to eight key focus (or action) areas is emphasis on certain types or phases of training or spot-inspection and serviceability of certain tools or parts or systems. Perhaps when it rains or gets below freezing some of these seven to eight areas become more important to increase attention on than the others, although all will remain important.

Well, now you're ready to go! Yep, that's right! You've got the ground safety discipline in a corner, but what about flight, and weapons safety? "You mean I have to do this separately for all three disciplines?" Yes you do. Fortunately, some key focus (or action) areas may cross over into one or more disciplines. However, within a targeted mishap

prevention plan there may be as many as 24 different key focus (or action) areas to track. Now, if you think that's too many items to track, consider how diverse your unit or base is in terms of mission complexity. With that in view, the number 24 might not seem so large.

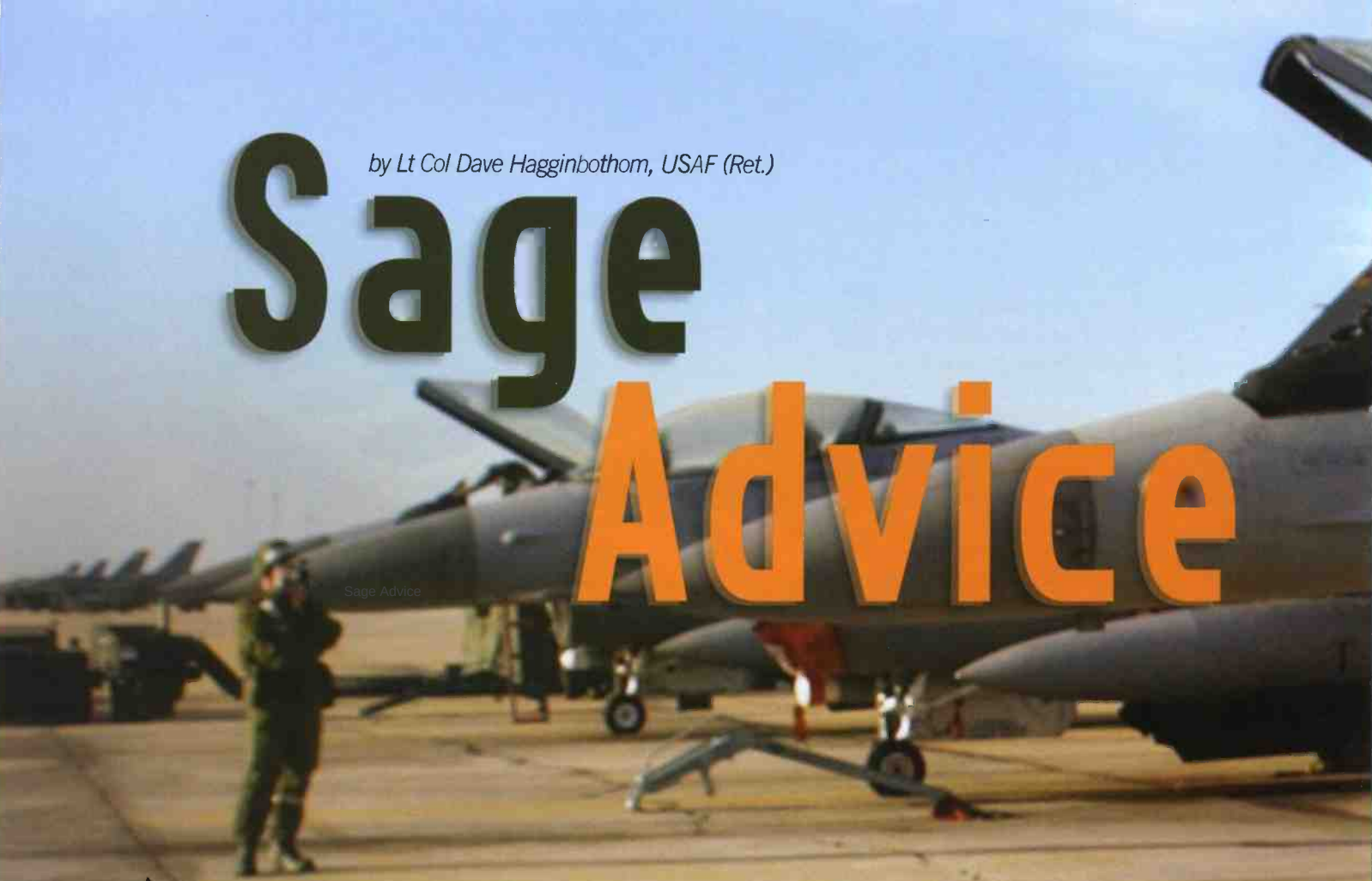
There's just one more trick. Make those responsible for a particular key focus (or action) area(s) accountable to the commander once a week/month during unit stand up for the status on their focus (or action) area(s) (e.g., metrics, actions). I am confident that if you do this your targeted mishap prevention plan will almost run itself. The only thing you'll need to do is a semiannual progress check to confirm the direction and magnitude of metrics to validate if your plan focuses on the difference making focus (or action) areas; if they don't, then change them.

As a former college professor once said, "that's it, there ain't no more!" Felt like you've been to school just reading this, huh? Your head probably hurts just from reading, let alone thinking about doing this yourself. Well, delegate out the tasks to your people and expect this to be a many-week project. Send your draft to other bases and get their input for a stronger plan (you'll be glad you did). It's really not that hard to do, and you'll learn a lot about our Air Force doing it. Of course, the alternative is reading another copy of Blue Four News (this time about your unit) or wiping that grin off your face as you look forward to a 30-day TDY as an accident board member.

Col Good is Director of Safety for Ninth Air Force and US Central Air Forces. He looks forward to helping you on your way with you own targeted mishap prevention plan. He can be reached at john.good@shaw.af.mil or at DSN 965-3179. Col Good offers special thanks to Colonels Creid Johnson and Mike Beard who were the impetus behind some of these concepts.

Photo by Mrs. Denise Gould

Photo by A1C Stacie Good



by Lt Col Dave Hagginbothom, USAF (Ret.)

Sage Advice

Almost two and a half decades ago when I was a brand new Air Force pilot, my first introduction to flight safety was via Military Airlift Command's slogan "Beware The AWTH" (Accident Waiting To Happen). The AWTH was embodied in a caricature of a menacing-looking gremlin a la The Twilight Zone. Since retiring, over a year ago, I've spent time reflecting back upon my flying career which spanned two decades and four major commands. The pages of my two flight log books revealed, at the macroscopic level, radically different experiences and required mindsets in each different aircraft and mission.

What's the applicability to USAF pilots today? You may have just been selected for the F-22A or will be sometime in the future for the F-35; your weapons system may be modified with a major block upgrade; or, you may simply find yourself back flying white jets. Regardless, complacency about potential hazards, whether from an under-exposure or over-exposure to In-Flight Emergencies (IFEs), increases the likelihood of situations requiring superior skills to prevail over less-than-superior judgment.

My first T-41 flight was on my 21st birthday and my fini-flight in the mighty Tweet was just 2 days prior to my 41st. In the interim, I logged over 3,400 flight hours in five different aircraft. My first assignment was in Operational Support Airlift (OSA) flying the CT-39 Sabreliner and C-21 Learjet.

OSA "seasoning" was second to none. In 3 years and 7 months after pilot training, I flew 920 sorties, logging nearly 1,600 flight hours. That's roughly 260 sorties and 450 hours per year. During that entire period, I recorded only nine IFEs and about the same number of weather diverts in my log book. That's only one out-of-the-ordinary occurrence for every 50 sorties -- about two or three chances per year to actually apply what we read about in Section 3 of the Dash One.

Contrast that with my next experience as initial cadre in the B-1. A favorite target of criticism, the Block B B-1 of the late eighties and early nineties was significantly different than the Block D and E B-1s that have garnered praise from the mid-nineties through today.

In back-to-back operational tours that included 5 years and 3 months actively flying "the Bone," I logged 224 sorties and an even 1,000 flight hours. When I tallied the number of IFEs, air aborts for weather or maintenance, and safety reportable incidents, the total was 48! (At that time, a sortie without at least 2 pages of 781 write-ups was remarkable.) Overall that meant that one out of every five B-1 sorties had some sort of out-of-the-ordinary incident. Furthermore, flying an average of only 41 times each year -- eight of which had an IFE or air abort -- gave pilots good reason to add tabs to their "abbreviated" checklists and in-flight guides.

From being an instructor/aircraft commander in the C-21 to a combat mission ready Instructor Pilot (IP) in the B-1, my sortie count decreased by 84 percent and hours flown decreased by 59 percent. These decreases happened all while IFE/air aborts increased tenfold from 2 to 20 percent in an incredibly

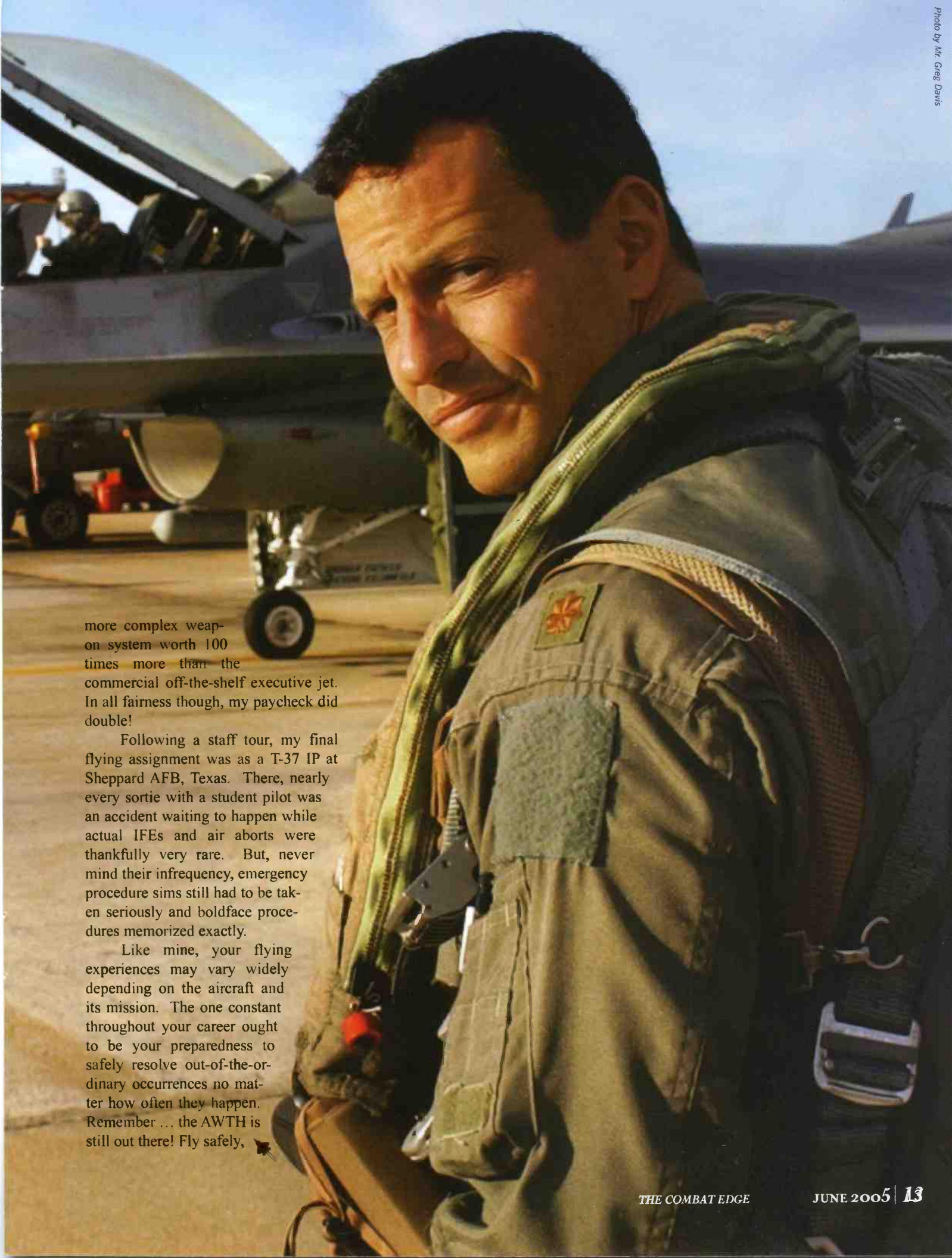
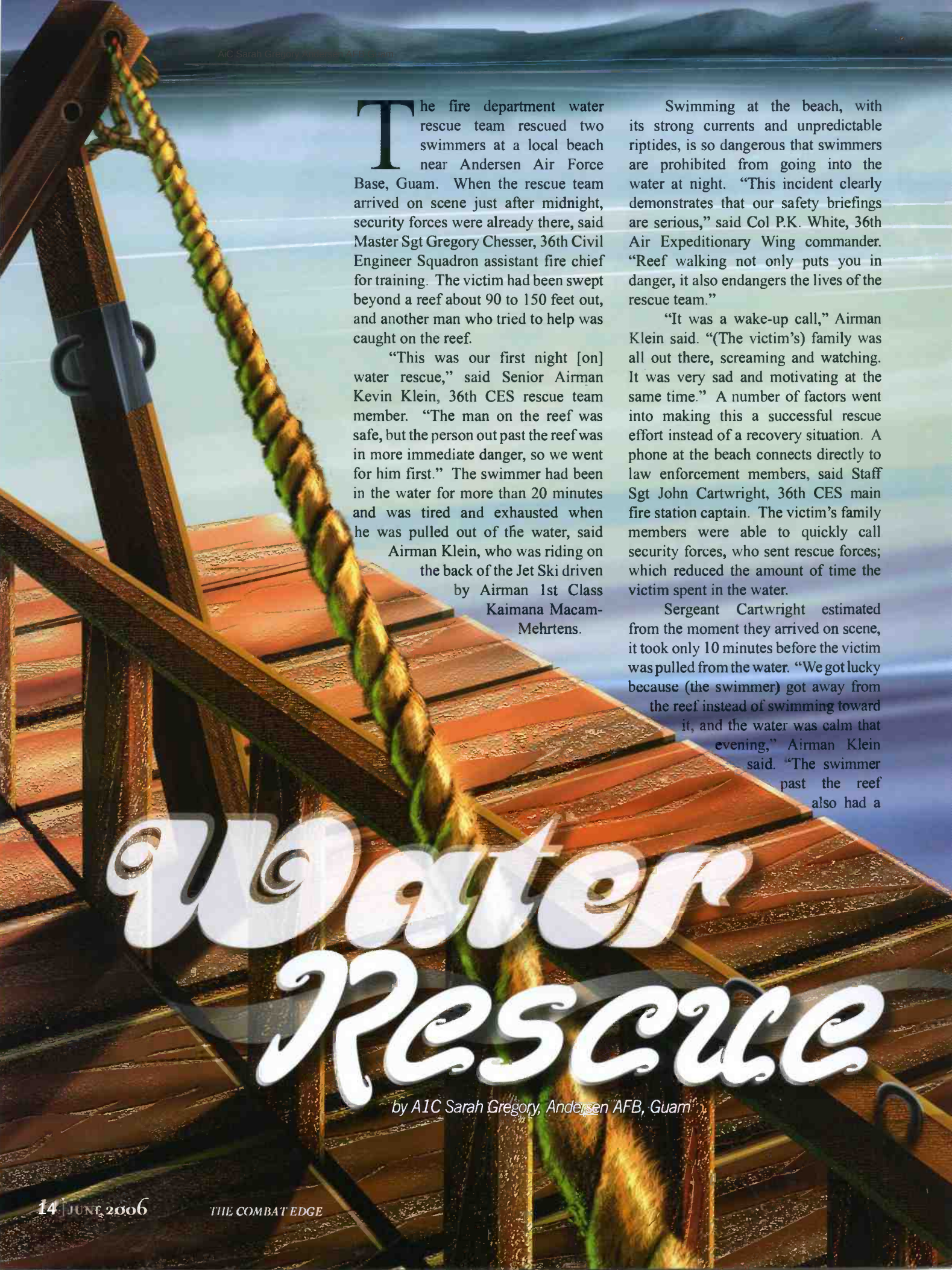


Photo by Mr. Greg Davis

more complex weapon system worth 100 times more than the commercial off-the-shelf executive jet. In all fairness though, my paycheck did double!

Following a staff tour, my final flying assignment was as a T-37 IP at Sheppard AFB, Texas. There, nearly every sortie with a student pilot was an accident waiting to happen while actual IFEs and air aborts were thankfully very rare. But, never mind their infrequency, emergency procedure sims still had to be taken seriously and boldface procedures memorized exactly.

Like mine, your flying experiences may vary widely depending on the aircraft and its mission. The one constant throughout your career ought to be your preparedness to safely resolve out-of-the-ordinary occurrences no matter how often they happen. Remember ... the AWTH is still out there! Fly safely,



Water Rescue

by A1C Sarah Gregory, Andersen AFB, Guam

The fire department water rescue team rescued two swimmers at a local beach near Andersen Air Force Base, Guam. When the rescue team arrived on scene just after midnight, security forces were already there, said Master Sgt Gregory Chesser, 36th Civil Engineer Squadron assistant fire chief for training. The victim had been swept beyond a reef about 90 to 150 feet out, and another man who tried to help was caught on the reef.

"This was our first night [on] water rescue," said Senior Airman Kevin Klein, 36th CES rescue team member. "The man on the reef was safe, but the person out past the reef was in more immediate danger, so we went for him first." The swimmer had been in the water for more than 20 minutes and was tired and exhausted when he was pulled out of the water, said Airman Klein, who was riding on the back of the Jet Ski driven by Airman 1st Class Kaimana Macam-Mehrtens.

Swimming at the beach, with its strong currents and unpredictable riptides, is so dangerous that swimmers are prohibited from going into the water at night. "This incident clearly demonstrates that our safety briefings are serious," said Col P.K. White, 36th Air Expeditionary Wing commander. "Reef walking not only puts you in danger, it also endangers the lives of the rescue team."

"It was a wake-up call," Airman Klein said. "(The victim's) family was all out there, screaming and watching. It was very sad and motivating at the same time." A number of factors went into making this a successful rescue effort instead of a recovery situation. A phone at the beach connects directly to law enforcement members, said Staff Sgt John Cartwright, 36th CES main fire station captain. The victim's family members were able to quickly call security forces, who sent rescue forces; which reduced the amount of time the victim spent in the water.

Sergeant Cartwright estimated from the moment they arrived on scene, it took only 10 minutes before the victim was pulled from the water. "We got lucky because (the swimmer) got away from the reef instead of swimming toward it, and the water was calm that evening," Airman Klein said. "The swimmer past the reef also had a

flashlight with him, which is how we knew he was in the water and how we could locate him." Although the water rescue team's Airmen train monthly to keep their response time down and to have practice in the water, their training is usually during the day.

"We have never trained at night," Sergeant Cartwright said, explaining it was usually too dangerous to try. That night the tide was low, which increased the risk of hitting the reef. The rescue team had to be exactly in the cut opening in the reef, or their Jet Skis would have gotten stuck on top of it, officials said.

Conducting a night rescue presented challenges to the team they normally do not experience during daytime. "We couldn't see the man in the water, and it was difficult finding the cut in the reef because we couldn't tell where the waves were breaking," Airman Klein said. "It's a whole different world at night -- it's a lot scarier."

The Airmen credit their success to their intense training and their group effort. They have to complete a certification course that covers Jet Ski operations, ocean currents and conditions and a swimming test, Airman Klein said. "It's all about teamwork and relying on your driver," he said.

"I'm very proud of our rescue team," Colonel White said. "They saved a man's life out there; what they did was nothing short of heroic."


Photo by AMN Edmund Gibbons

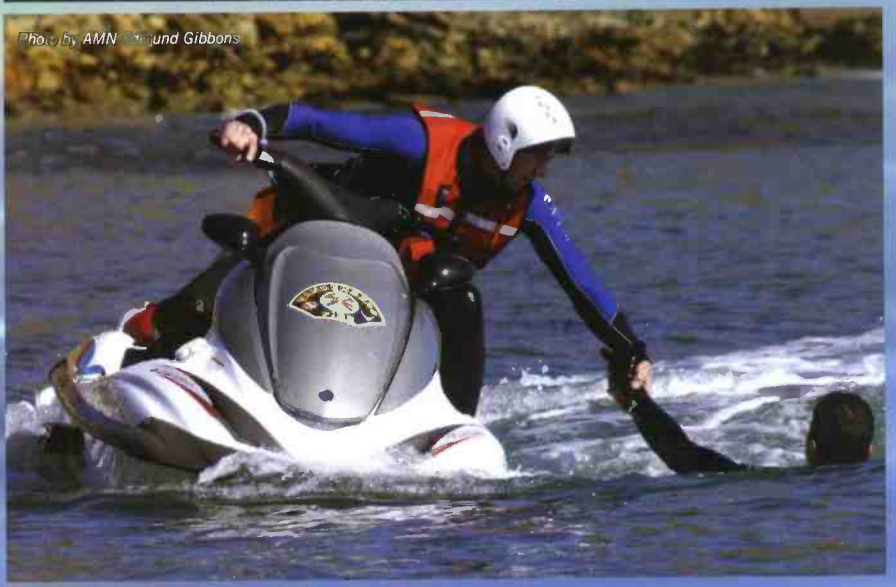


Photo by AMN Edmund Gibbons


Photo by SSgt Jerry E. Clemens


Photo by SSgt Jerry E. Clemens

DEPARTMENT OF THE AIR FORCE
OFFICE OF THE CHIEF OF STAFF
WASHINGTON DC

12 APR 2006

MEMORANDUM FOR ALMAJCOM-FOA-DRU/CC

FROM: HQ USAF/CC
1670 Air Force Pentagon
Washington, DC 20330-1670

SUBJECT: Suicide Prevention

Ten years ago, the Air Force embarked on an unprecedented community campaign to prevent suicides. The attached 11 initiatives of the Air Force Suicide Prevention Program (AFSPP) focuses on our core value that every Airman is a wingman and responsible for taking care of each other.

We've seen a 30 percent drop in Air Force suicide rates since the implementation of AFSPP. However, we continue to lose too many Airmen to suicide: 31 in CY05 and 12 so far in CY06. One recurring theme is that the problems faced by Air Force suicide victims were often unknown to the unit, or the unit didn't realize the full severity of these problems. It is imperative that frontline supervisors take time to learn what is going on in the lives of their subordinates, both on and off duty. Frontline supervisors are our first line of defense in preventing suicide, and they must know and understand their personnel well enough to detect troubled fellow Airmen and take effective preventive action. Commanders and First Sergeants play a vital role in engaging with frontline supervisors to identify those at risk and get them help.

Every Airman is a vital national treasure. I ask commanders to ensure the full implementation of all 11 initiatives on their installations.

My point of contact for this issue is Col Whit Campbell, AF/SGOC, DSN 297-5328, or whit.campbell@pentagon.af.mil. Suicide prevention is a total community effort, and I need your full engagement in caring for our Airmen.

T. MICHAEL MOSELEY
General, USAF
Chief of Staff

Attachment:
11 Initiatives of the Air Force Suicide Prevention Program

Air Force Suicide Prevention Program: 11 I

#1 Leadership Involvement: Air Force leaders actively support the entire sp
prevention initiatives in our community. Regular messages from the CSAF, ot
base commanders motivate our community to fully engage in suicide prevention

#2 Addressing Suicide Prevention Through Professional Military Education
education is included in all formal military training.

#3 Guidelines for Commanders: Use of Mental Health Services: Commanders
how and when to use mental health services, and their role in encouraging early hel

#4 Community Preventive Services: Community prevention efforts carry more im
individual patients one at a time. The Medical Expense and Performance Reporting S
was updated to effectively track both direct patient care activities and prevention serv

#5 Community Education and Training: Annual suicide prevention training is provi
and civilian employees in the USAF.

#6 Investigative Interview Policy: The period following an arrest or investigative interv
risk time for suicide. Following any investigative interview, the investigator is required t
individual directly to the commander, first sergeant, or supervisor. The unit representative
responsible for assessing the individual's emotional state and contacting a mental health pr
question about the possibility of suicide exists.

#7 Critical Incident Stress Management: Trauma Stress Response teams were established
to respond to traumatic incidents such as terrorist attacks, serious accidents, or suicide. These
personnel deal with the emotions they experience in reaction to traumatic incidents.

#8 Integrated Delivery System (IDS) and Community Action Information Board (CAIB):
Force, MAJCOM, and base levels, the CAIB and IDS provide a forum for the cross-organizatio
and resolution of individual, family, installation, and community issues that impact the readiness
force and the quality of life for Air Force members and their families. The IDS and CAIB help c
the activities of the various base helping agencies to achieve a synergistic impact of community pr

#9 Limited Privilege Suicide Prevention Program: Patients at risk for suicide are afforded incre
confidentiality when seen by mental health providers (Limited Privilege Suicide Prevention Prograr
Additionally, Limited Patient-Psychotherapist Privilege was established in 1999, limiting the release
patient information to legal authorities during UCMJ proceedings (see AFI 44-109 for additional det

#10 IDS Consultation Assessment Tool: The IDS Consultation Assessment Tool was released in
December 2005. This tool, administered upon the request of the commander, allows commanders to
assess unit strengths and identify areas of vulnerability. Commanders can use this tool in collaboration
with IDS consultants to design interventions to support the health and welfare of their personnel.

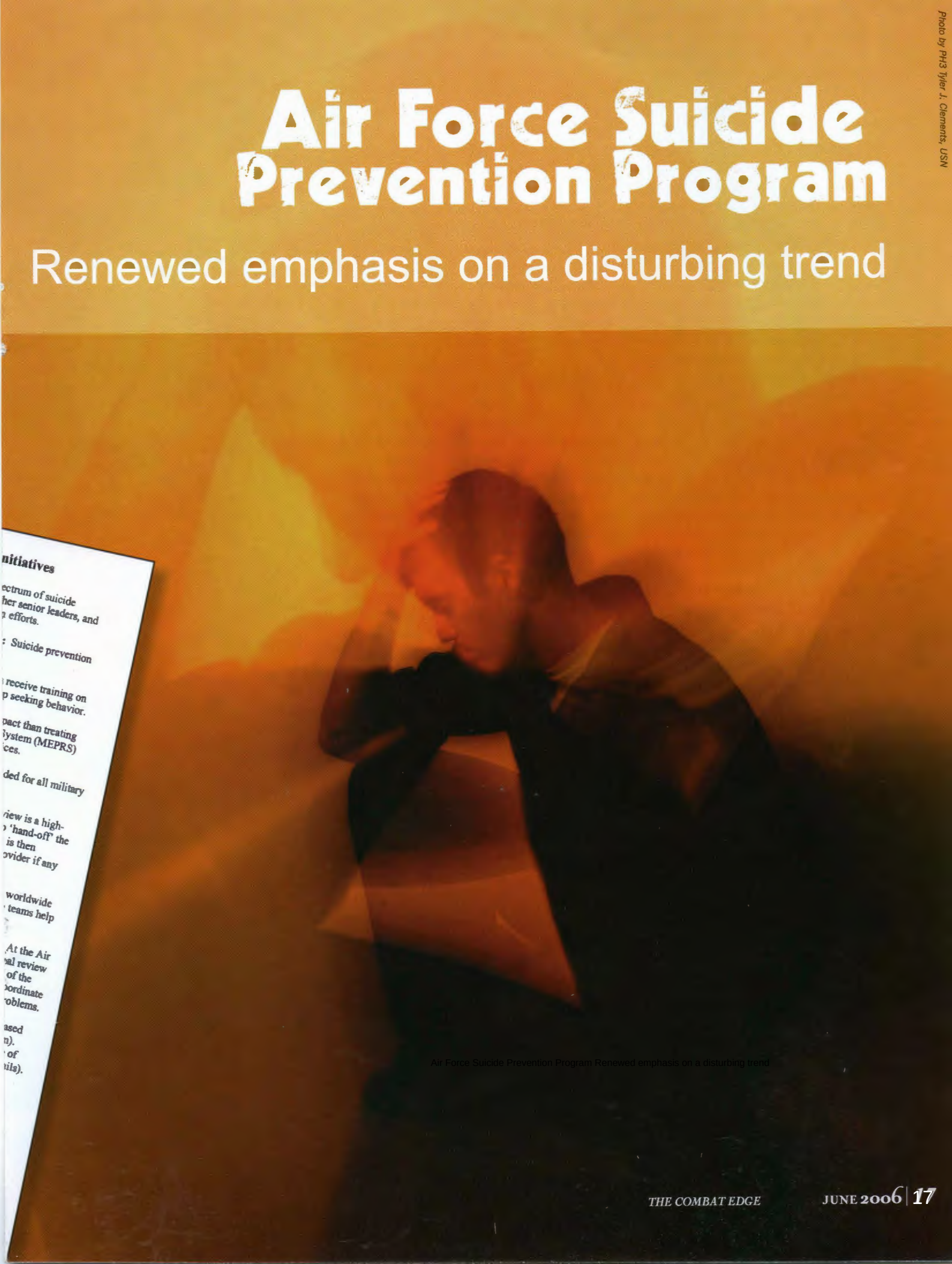
#11 Suicide Event Surveillance System: Information on all Air Force active duty suicides and suicide
attempts are entered into a central database that tracks suicide events and facilitates the analysis of
potential risk factors for suicide in Air Force personnel.

The 11 initiatives of the Air Force Suicide Prevention Program are described in detail in AFPAM 44-160.

Air Force Suicide Prevention Program

Renewed emphasis on a disturbing trend

Photo by PH3 Tyler J. Clements, USN



Air Force Suicide Prevention Program Renewed emphasis on a disturbing trend

In January 2005, my life was changed forever. That was the month I decided that I was going to learn how to ride a motorcycle. I made this decision even though I had lost a close friend in a motorcycle accident almost 5 months earlier.

I prepared by taking the required motorcycle safety course and consulting my mother, who also rides. As a First Sergeant in the U.S. Army, my mother has dealt with many motorcycle incidents and explained to me the dangers of riding. I have to admit I was excited, but also a little apprehensive about buying a bike.

I was lucky to have many coworkers in my flight help me to make the transition. Like many people do in their first couple months of riding, I did drop my bike, but a close friend reassured me and advised me to take my time becoming comfortable with my bike. All of my training and advice from others resulted in me having the best time ever this past summer. And the fall riding season was going great … until one fateful Saturday in October.

The weather had been terrible for the previous couple of weeks, but a good weekend had finally arrived. I called up my close friends to see if anyone wanted to ride, but no one was home, so I left a bunch of messages. Around 11:00 a.m., one of my friends returned my call. He told me a group of people were riding over to Greenville, N.C., to eat lunch, ride around town, and then come back. I couldn't leave at that time, so I told them I was going to stay back.

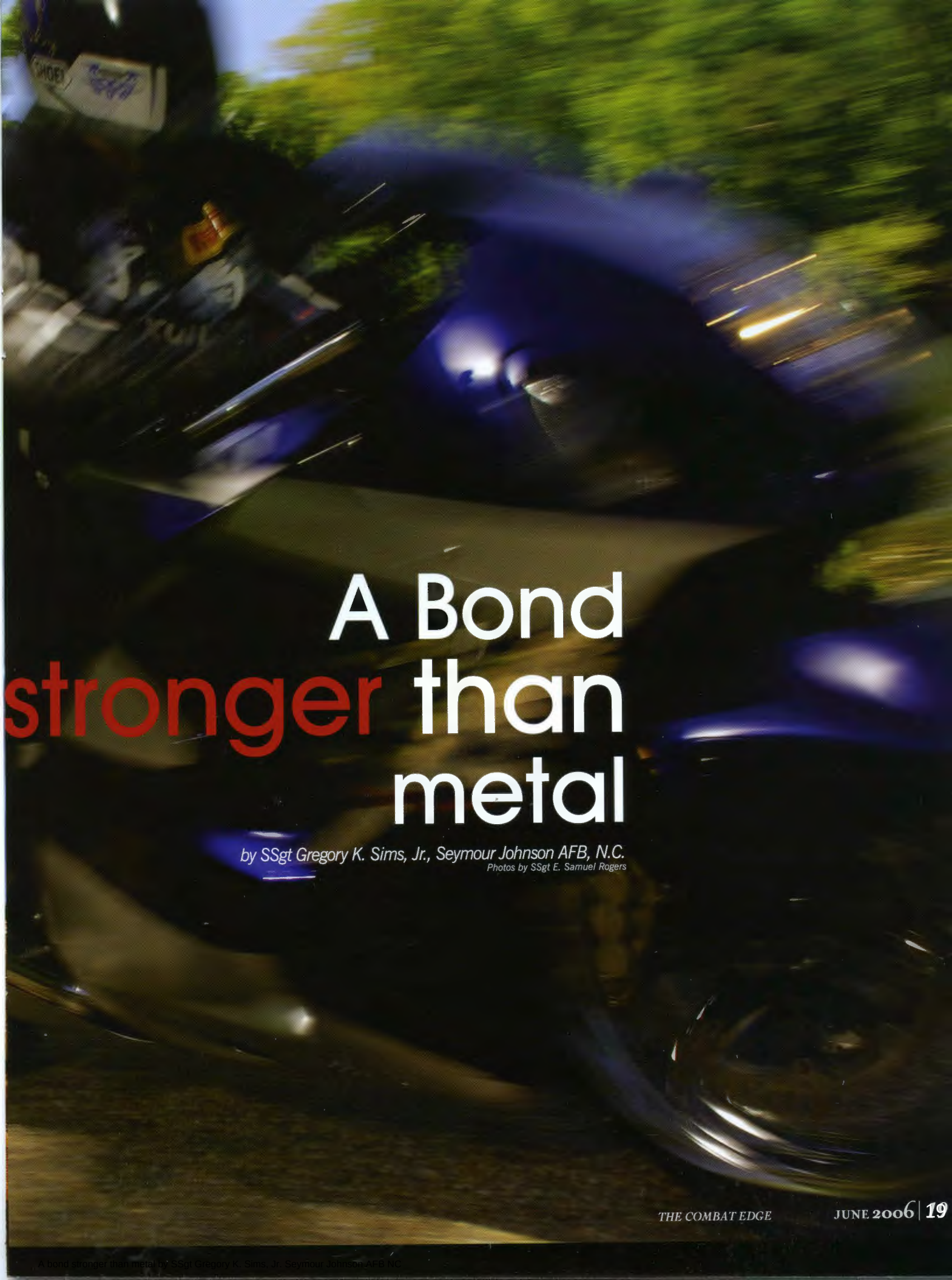
Around 12:30 p.m., the same close friend who had helped me get comfortable with riding called. He wanted to know if I still wanted to ride to Greenville and meet up with the others. I jumped at the opportunity so we made plans for him to come to my house at 2:00 p.m. I went outside and cleaned my bike, checked the tires and brakes, and filled the tank.

My friend showed up on time as usual. I grabbed my jacket and made sure I had a reflective belt in the pocket in case we headed home after dark. When I got outside, I saw that he had his girlfriend riding along with him as a passenger. She and I were coworkers and good friends; she was an awesome person to work with and we hung out often. Needless to say, I was excited she was coming along for the ride. As I got on my bike, I prayed (as I always had) for a safe journey. I need all the help I can get when tackling the inherent dangers of riding! We were on our way before long, and it was an absolutely perfect day: no clouds, light traffic, and no wind. That meant we could open up a little on the throttle if we wanted to; in other words, speed.

At this point I need to confess to having a history of speeding. Speeding is a reckless behavior on a bike, and I, like many other riders out there, have sped. However, that practice came to an abrupt end after a ride I took down a 10-mile stretch of road where I pushed my bike to the limit. When I got home that day, I couldn't wait to tell my wife what I had done. My excitement was quickly extinguished when she went ballistic. She yelled at me so bad that my 4-year-old son had to consol me afterwards. Out of respect for my wife, I made a pact with her that I would never speed like that again.

My friend on the other bike knew about this pact and had thought it was a good idea. He had been riding all types of motorcycles for about 8 years and was very experienced and knowledgeable of road conditions. It was because of his advice that I had steered clear of other reckless behaviors (e.g., wheelies, endos, etc.) being done in some of the local riding clubs. Of course, I always got to hear a lot of jokes about being in the "puppy pack," but for me, things were cool.

As we left town and turned onto the country road that leads to Greenville, we cruised moderately down each stretch and around each curve. We eventually came to a light and turned onto a two-lane road that runs for about 10 miles and has very small curves in-between. About 2 miles down the road, an open straightaway came up where you could see almost a mile ahead. I was riding behind my friends and saw his girlfriend adjust a little bit on the back seat and hug him tight. There appeared to be no oncoming traffic, so I figured they were going to take off, and that's exactly what they did. I gave them a 4-second cushion and proceeded to do the same. But as soon as I shifted, I remembered the pact I had made with my wife and let off instantly. I knew I was going to hear the "puppy pack" jokes again, but



A Bond stronger than metal

by SSgt Gregory K. Sims, Jr., Seymour Johnson AFB, N.C.
Photos by SSgt E. Samuel Rogers

that was fine. The group I normally ride with waits for me, and anyone else, to catch up after they dart off, so I figured my friend would do the same thing.

As I eased up, I remember seeing my friend come up behind a brown truck, which kind of blended into the foreground. On the opposite side, further down the road was a dark colored vehicle. My friend was able to get around the truck in time, but then I noticed the brake lights on the truck come on as the dark colored car began to turn around. It was a State Trooper, and he was going after my friend to pull him over. I remember thinking how much his insurance was going to shoot up from the ticket when I realized that the trooper had his lights on, but not his siren. What I witnessed next made time stand still.

The road curved slightly as it approached an intersection. A large white truck was coming to the intersection from the left. It came to a rolling stop and then proceeded to turn left onto the road going in the same direction we were. I am sure the truck did not see my friend coming because he was traveling so fast.

My friend struck the passenger side of the truck near the headlights. After the initial contact, his bike ran into the back of a smaller truck further ahead of the intersection. I saw both my friends fly off the bike and make contact with that smaller truck.

It took about 7 or 8 seconds for me to catch up to the accident scene. By the time I arrived, the trooper was already out of his car checking people. He checked both my friends' vitals and then checked the passengers of the two trucks.

As I approached both my friends, I did not think about how bad the scene looked. Instead, my training kicked in, and I thought about the aid I could try to administer. They were both in bad shape. My friend's girlfriend was closest so I checked her first. Her helmet had come off and, she had no pulse and was not breathing. I ran and checked my friend and did not see him breathing either. They were both lying on their stomachs and I was afraid to turn them over and administer CPR in case that would worsen a possible neck injury. I felt so completely helpless.

Shortly after, the emergency medical technicians arrived. They confirmed that my friend's girlfriend had died on impact, and, although he wasn't breathing, he still had a pulse. In about 5 minutes, which seemed like an eternity, he was flown to the nearest hospital, where he later passed away as well.

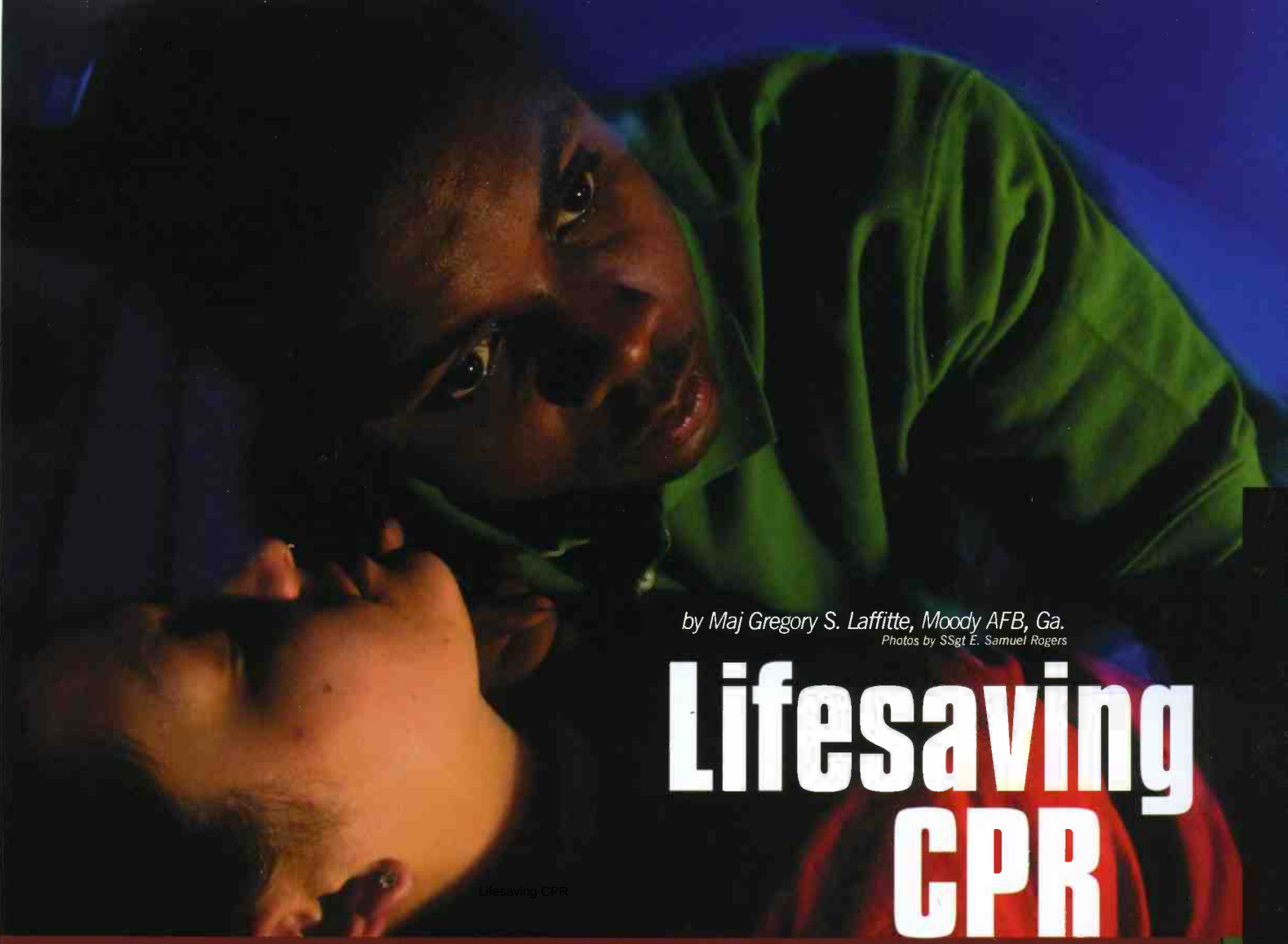
I stayed until the scene had been cleared. It was the most devastating event I have ever witnessed in my short 25 years of life. I remember on my ride

home feeling empty inside. Visions of the accident played back and forth in my head. It took a day or two to realize my friends were gone.

My chain of command somehow found out about the reason I didn't speed that day. While I was proud of myself for keeping my pact with my wife, it hurt to think about the difference that had made. I was thankful I had trusted my heart, but also upset at myself for not reminding my friends about the pact before riding that day -- a day when it could have made the difference between life and death. I realize the responsibility lies with each rider, but that is more difficult to rationalize when you care about the people involved or when you actually watch them lose their lives.

I will never forget having to make those calls to tell friends about the accident or seeing the expression on the faces of the First Sergeant and Commander. If I had been able to capture their faces on film, those pictures would have spoken a thousand words about the depth of the loss we were all experiencing.

I know from the bottom of my heart, I will forever remember my friends. While I thought that telling my wife that day about my speeding was the wrong move, it turned out to be the best thing I have ever done. Without that pact with my wife, I am sure I would have followed my friends and ended up losing my life. While I had felt "forced" to make it with her, it ended up saving my life. I will always remember that. I will also always let others know about that terrible day with the hopes that it will save another life. What I discovered that Saturday was that the bond between two hearts ended up being stronger than the welds holding the metal pieces of that motorcycle together.



Lifesaving CPR

by Maj Gregory S. Laffitte, Moody AFB, Ga.
Photos by SSgt E. Samuel Rogers

Lifesaving CPR

June 2, 2005, was a special day for our family because my daughter was turning 16. The evening plan was to have a small dinner party with a few of her friends. My responsibility as "Dad" was to prepare and serve my world famous hickory smoked chicken.

I was particularly excited about my daughter's gift this year. After a lengthy search for the perfect present, I had purchased a pellet rifle complete with metal silhouettes of big game animals for target practice. What more could a 16-year-old girl ask for? Smoked chicken and target practice; it just doesn't get any better than that!

I was standing in my driveway anticipating that flavorful hickory aroma when I saw my neighbors assisting another neighbor across the street. The woman appeared sick and in need of attention. While I only knew her as the middle-aged neighbor who always waved when I passed her, something definitely was not right.

I ran down the street to her house and went right in. Her dogs were barking out of control and the other three neighbors were standing around casually, unsure about what to do. The woman was lying on a couch in a completely unnatural position with her eyes rolled back and not breathing. I quickly realized no one else was aware of the seriousness of the situation.

When I asked what was wrong with her, the three neighbors told me she had blood pressure and blood sugar problems and did not like to go to the doctor or take medicine. Staring at this lifeless woman, I experienced the classic sensation of "time standing still."

I immediately performed the classic "look, listen, and feel" drill, confirming that I had a non-responsive, non-breathing victim without a palpable pulse. My Cardio Pulmonary Resuscitation (CPR) training kicked in and I began to go through the steps I had been taught over the years.

Someone helped me get the unconscious woman to the floor where I then initiated the rescue breath sequence. When the two rescue breaths failed to revive her, I directed someone call 911 and asked another person to assist me in performing two-person CPR. Together we accomplished the chest compressions and rescue breaths exactly by the book.

After what seemed like an eternity the victim opened her eyes and appeared to breathe on her own! We stopped CPR and rolled her onto her side. This "recovery" position would allow her to vomit without aspirating her stomach contents into her lungs. She did get sick and within seconds was once again unconscious and had stopped breathing.

We rolled her again onto her back and gave her two additional rescue breaths. She opened her eyes again, but was obviously confused and completely disoriented. That was when I noticed a

droop on the right side of her face and that her speech was remarkably slurred.

We returned her to the recovery position where she again stopped breathing for the third time! Fortunately, we were able to revive her within minutes of the ambulance arriving. The paramedics then took over and transported her to the Emergency Room for follow-on care. It was later determined that she had suffered a stroke.

After the ambulance left, I walked home, finished cooking dinner, and celebrated my daughter's 16th birthday. The chicken was good-to-go, and she loved the pellet rifle!

Many of us have had CPR training. Those of us who have actually had the opportunity to use it know how critical this training is. According to the Red Cross, last year 220,000 Americans died of sudden cardiac arrest, which is almost one person every 2 minutes. You never know when you will find yourself in the vicinity of one of those people. Take the training seriously and be ready at all times – someone's life might just depend on it.

The two goals of CPR are to keep oxygenated blood flowing through the body (especially vital organs like the heart and brain) and to keep air flowing in and out of the lungs. The cardiac chain of survival begins with **CHECK-CALL-CARE**:

1. CHECK. When you recognize an emergency situation requiring CPR, you should first check to make sure the scene is safe for you and any bystanders.

2. CALL. Once the scene is secured, call or have someone call 911 or the local emergency number.

3. CARE. These are the basic CPR steps for an adult:

a. Check the person for responsiveness by tapping and shouting. If the person does not respond, check their airway.

b. Open the person's airway by tilting their head and lifting their chin. Check the person's breathing by looking, listening with your ear, and feeling the person's chest. If the person is not breathing, check their circulation.

c. Circulation can be determined by checking the person's pulse. This is done by placing your hand at the side of the person's neck. If you do not find a pulse, begin CPR.

d. With the head tilted back, give two rescue breaths by pinching the nose, covering the person's mouth with yours, and blowing until you see the chest rise. Each breath should take 2 seconds. If the person does not respond by breathing normally, coughing, or moving, begin chest compressions.

e. Position palms of hands in the center of the chest and firmly push down 1 1/2 to 2 inches on the chest 15 times. Pump at the rate of 100 per minute, which is faster than once per second.

f. Continue with two breaths and 15 pumps until help arrives. In two-person CPR, the person pumping the chest stops while the other gives mouth-to-mouth breathing.

Both the American Heart Association (AHA) and the American Red Cross provide CPR training. To find a class near you, contact your local Red Cross or the AHA at 1-800-AHA-USA-1 or 1-800-242-8721. You can also locate a class by going to the AHA website, www.americanheart.org. If a CPR course is not available near your location, the AHA offers a self-directed personal CPR kit for under $30.00 that takes 22 minutes to learn the core skills of CPR.

Spinning out of Control

by TSgt Donnie Reid, Davis-Monthan AFB, Ariz.

Dusk had descended upon us, and it was just starting to get dark. We'd turned on the "Lite-Alls" about 10 minutes before, and the lights on the gantry were starting to make a difference at the "Off-load" side of the Munitions Assembly Conveyor. We had six MK-82, 500-pound bombs with low drag fins fitted with fuzes left to wire and place on a trailer before we were done for the day.

The shift supervisor, a Staff Sergeant, had left me in charge of the operation prior to leaving for the flight line to answer a maintenance call. That left five of us working on the pad; myself (a Senior Airman who had taken over as crew chief), another Senior Airman who had sewn on the stripe about a month earlier, two Airmen First Class and a fairly new Airman. About 20 minutes after our shift supervisor departed for the flight line, the Quality Assurance (QA) Inspector pulled up to the pad.

I picked up my crew book, and let my crew know I was leaving to go talk to the QA Inspector. As I picked up the book, I noticed that the book still showed the SSgt as the crew chief and it listed my name as handling a fire extinguisher. I quickly lined through the SSgt's name and put my name in the crew chief block. I also added the QA Inspector's name as a casual observer as well as updating the crew size to five. As I began briefing the inspector, I noticed movement out of the corner of my eye, and quickly glanced over in time to see the young Airman with a safing pin in his left hand, while turning the arming vane with his right pointer finger.

I stood frozen for what seemed like a lifetime, but was only a couple of seconds, unsure as to what to do next. I came out of my trance and asked the QA Inspector to evacuate following the crew member that was tasked to perform evacuation in case of emergency. With that done, I went over to check the fuze. In my mind, I began to realize I had a partially or fully armed fuze on my pad, and I quickly snatched the safing pin away from the young Airman and told him to evacuate as well. While I was putting the safing pin back into the arming vane, I called Munitions Control to have them notify Explosive Ordnance

Photo by A1C Anthony Nelson, Jr.

Photo by Kimberly A. Dews

Photo by Tsgt Robert W. Valenca

Disposal (EOD) to come out and check on the safety of the fuze. The arming windows still showed green (unarmed) but I didn't want to take any chances.

EOD responded and confirmed the fuze was safe. The crew and QA returned to the pad as we finished up stringing the arming wire.

I learned a couple of things that day. First, when you are responsible for any operation, not just one where a potential explosive mishap can kill everyone in the area, ensure that the operation stops if you have to leave it for any reason or any length of time. In my case, briefing the QA inspector would have taken a couple of minutes, but stopping the operation and preventing over 45 minutes of headaches would have only taken seconds.

Second, when taking an operation over as the crew chief, take a look at your crew book (or safety data page or whatever your team uses to brief responsibilities and duties for the operation) and ensure everyone knows what they are assigned to do. Ensure to document the changes and fill out paperwork properly and completely.

Finally, I should have taken more time to understand what the young Airman had been doing up to that point, as well as what he knew about the current operation and if he was trained to perform the task at hand. I later discovered that, prior to me taking over the operation; the young Airman's only job was to shadow the crew chief. When the young Airman had asked me what I wanted him to do, I set him to work on stringing the arming wire. Stringing the arming wire is only a small part of the entire operation, but the Technical Order (T.O.) specifically states that if fuze safing devices are not present, or if an armed indication is present, the fuze is considered partially armed or armed. The T.O. also states that the appropriate personnel need to be notified should a partially armed or armed condition exist.

Ultimately, I learned a great deal about what I need to be doing as a crew chief. Luckily a potential explosive mishap was avoided and we all lived to see another day. Although it would have taken the young Airman a bit more time spinning the arming vane before getting the fuze to arm, the situation never would have come up if I had properly briefed and monitored him.

Monthly Award Winners

Aircrew Safety
Award of Distinction

Capt Jesse Winters and A1C Sean Gillespie distinguished themselves while demonstrating their exceptional airmanship while faced with multiple aircraft emergencies. On the first occasion, Capt Winters and A1C Gillespie were recovering an MQ-1 aircraft that was experiencing a flight control malfunction. With an aileron servo overheating and facing impending aileron failure, they successfully recovered the aircraft with only minimal aileron control available. They prepped and launched a second aircraft as a spare. Takeoff and climb out were uneventful, but upon reaching altitude, an engine oil seal failed and the aircraft lost all engine oil within seconds. With the loss of oil, the engine failed entirely. Demonstrating excellent crew resource management skills they were able to successfully position the aircraft for and execute a flawless engine-out recovery to Balad. Later in the same month, the same crew took control of an aircraft that was missing the nose wheel and much of the nose strut. The aircraft was low on fuel and winds out of aircraft limits and increasing. Capt Winters and A1C Gillespie had no option but to attempt a landing. Again, displaying remarkable crew coordination and superb airmanship, they successfully landed the aircraft without further incident. Capt Winters managed to keep the nose strut clear of the ground, maintaining runway alignment with rudder, until the aircraft, aided by the wind, was at nearly a complete stop. There was no further damage to the aircraft or to Balad's only instrument runway. Capt Winters' and A1C Gillespie's demonstration of remarkable skill and top-notch crew resource management saved three of the Air Force's and CENTCOM's most requested theater assets in the course of a single month — making them more than deserving of this award for which they are nominated.

Capt Jesse Winters, A1C Sean Gillespie
46th Expeditionary Reconnaissance Squadron
Balad Air Base, Iraq

Pilot Safety
Award of Distinction

Capt Nicholson was #2 of a 2-ship on an F-15C continuation training sortie. Shortly after entering the airspace, the flight was performing a nose low descent to transition into the low altitude structure. During his descent at approximately 30 degrees nose low and 450 knots, the master caution light illuminated with a roll ratio and pitch ratio light and the sluggish flight controls. Despite the flight control difficulties, Capt Nicholson leveled out and retarded the throttle and began to slow the aircraft. Upon level out, the roll and pitch ratio lights went out and the hydraulic and left ramp light illuminated indicating a hydraulic problem. Capt Nicholson immediately made a decision to return to base. After a short period, the Utility A light transitioned to a Utility B light, which is indicative of a Utility hydraulic leak. He immediately accelerated the aircraft to expedite the recovery. Capt Nicholson took the lead and directed his wingman to perform a battle damage (BD) check to look for any leaking hydraulic fluid. The BD check revealed a significant amount of hydraulic fluid on the belly of the aircraft. Capt Nicholson immediately declared an in-flight emergency with air traffic control and informed the supervisor of flying. He noted a drop in hydraulic pressure by a few hundred psi; realizing the problem was quickly escalating and would result in a total utility hydraulic failure, he wisely decided to continue the approach without delay and get the aircraft on the ground. After safely landing and stopping the aircraft, and awaiting the fire crew, Capt Nicholson noticed a rapid drop in hydraulic pressure. Additionally, the right hydraulic pump light began to flicker and the left brake was losing pressure. Recognizing this as an imminent total utility hydraulic failure, he had the fire crew immediately chock and pin the aircraft before loss of brakes and landing gear pressure. During maintenance investigation, a break in the hydraulic pressure line forward of the Fuel Oil Heat Exchanger was found.

Capt Matthew J. Nicholson
60th Fighter Squadron
33rd Fighter Wing
Eglin AFB, Fla.

Ground Safety

Award of Distinction

SSgt Michael Pettus and SrA Charles Willis averted a potential disaster due to their safety awareness during the recent Phase II exercise. Both men were inventorying weapons to be given out to the 20 CES security team at the start of their shift. They started loading the empty magazines with ammunition after their inventory was complete; however, they immediately noticed the rounds to be loaded were live rounds and not blanks. They immediately secured all rounds and weapons once they realized the presence of live ammunition. The 20 CES unit deployment managers and security forces were quickly notified. All weapons, magazines and ammunition were secured until the completion of a security forces investigation. Authorization was given to reissue weapons several hours later once everything was deemed safe; however, base leadership later decided to continue the exercise without weapons due to the possible safety concerns. Every member of the 20 CES is armed during an exercise and they typically fire hundreds of rounds. Firing live rounds instead of blank rounds could have led to fatalities and the subsequent investigations would have crippled the wing's ability to effectively continue the mission. The Phase II exercise was completed with no safety incidences as a result of the ammunition problem. SSgt Pettus and SrA Willis' confidence and quick decisions saved Shaw AFB from potential disaster and ensured the safety of all Airmen involved with the exercise.

SSgt Michael E. Pettus, SrA Charles D. Willis
20th Civil Engineer Squadron
20th Fighter Wing
Shaw AFB, S.C.

WANTED

~PREFERABLY ALIVE~

ONE NOMINEE PER CATEGORY, EACH MONTH AND QUARTER FROM EACH NAF/DRU, NGB AND AFRC UNIT.

Monthly Award Winners

Crew Chief Safety
Award of Distinction

SSgt Randall's attention to detail and superb commitment to maintenance safety prevented a possible U-2 Class A mishap. While supervising the installation of a U-2 aircraft's empennage (aft section), SSgt Randall noticed that the left lower attachment mount bolt was uncharacteristically difficult to install. He instructed his crew to remove the aft section for a cleaning and inspection of the bolt and nut plate assembly. Immediately, he discovered a crack on the nut plate and a broken nut plate retaining pin. SSgt Randall then removed the retaining pin and nut plate for a more thorough inspection and found marks on the pin that led him to believe the bolts were too long. He then initiated a thorough investigation of the remaining mount assemblies and researched technical data and blueprints for the proper nut plates and hardware. His investigation revealed that the two bolts used to secure the aft section to the fuselage were too long. Further inspection identified the right lower aft section mount nut plate and retaining pin was also damaged and broken. During the many previous aft section installations, the bolts pressed against the retaining pins causing significant damage to the structural integrity of the left and right lower aft section mounts. SSgt Randall ordered the necessary parts and oversaw the maintenance effort to return this aircraft to a fully mission capable status in just under 2 hours. Since there are only four bolts that secure the aft section to the fuselage SSgt Randall's discovery is of extreme significance. Had this grounding condition gone unnoticed any longer, the aircraft's aft section may have broken loose in flight rendering the aircraft completely uncontrollable. SSgt Randall's investigative initiative and outstanding dedication to safety certainly prevented the loss of life and safeguarded an invaluable national asset.

SSgt Jeremy Randall
9th Aircraft Maintenance Squadron
9th Reconnaissance Wing
Beale AFB, Calif.

Flight Line Safety
Award of Distinction

MSgt Morton led the development and implementation of protective cover faceplates for the B-2 fire extinguishing control panel and engine/APU control panel to prevent safety-of-flight incidents which could result in the loss of an aircraft. These systems have been inadvertently activated in-flight due to accidental switch depression, leading to engine shutdowns. Within 2 days of the Flight Safety office request to Research Engineering to investigate a solution to the problem, MSgt Morton had prototype designs ready for review and approval. His concept involved installing Plexiglas faceplates over the panels to provide protection from accidental contact. The faceplate does not cover the actual switches rather it provides a raised framework around the buttons essentially recessing them while allowing for positive access at all times for emergency use. He created detailed three-dimensional computer-aided drawings and quickly arranged Metals Tech support to locally manufacture the first article test faceplates. Less than a week later they were available for safety team review and demonstration on actual aircraft components. Once the final design was confirmed, MSgt Morton coordinated certification testing at Tinker AFB and assisted in preparation of the proposal package to make the faceplates a permanent modification to the B-2. He performed the first aircraft installation as part of the time compliance technical order (TCTO) evaluation for proper fit, function, and maintenance procedures. MSgt Morton's tireless efforts resulted in the validation and verification of TCTO 1B-2A-952 on 8 Mar 06, providing the B-2 and her crew permanent protection from accidental engine shutdown.

MSgt Carl A. Morton
509th Maintenance Operations Squadron
509th Bomb Wing
Whiteman AFB, Mo.

Unit Safety

Award of Distinction

An inspection of fuel tank 3A in an F-15A at Otis Air National Guard Base resulted in the unexpected discovery of deteriorating fuel cell foam. A meeting was immediately called by the 102 FW Plans and Scheduling Section to address the safety implications. With the cooperation of the 102 FW Fuels Systems Section, a self-initiated one-time inspection of the entire 102 FW F-15 fleet was directed to validate what type of foam was in each aircraft and to confirm the condition. This inspection discovered that numerous aircraft had either deteriorating fuel foam or the incorrect type of foam when compared to depot-level documentation in the aircraft forms. Those aircraft with deteriorating fuel foam had particles in the pump and filters of the Jet Fuel Starter (JFS) unit with severe deposits in the aircraft boost pumps. This inspection identified depot-level discrepancies with aircraft maintenance records, corrected this potentially disastrous hidden problem, and provided sufficient data to initiate an Air Force-wide Safety Time Compliance Technical Order (TO 1F-15-1533 dated 23 Jan 06) to inspect all F-15 aircraft for fuel cell foam deterioration. The foresight of the 102 FW Plans and Scheduling Section and the aggressive action of the Aircraft Fuels Systems Section averted a potentially catastrophic fuel system failure for the entire F-15 fleet of aircraft.

102nd Aircraft Fuels Systems, Plans, & Scheduling Section
102nd Fighter Wing
Otis Air National Guard Base, Ma.

ACC Safety Salutes Superior Performance

Maj Barry Hutchison, B-1B IP
Capt Jason Jackson, B-1B IWSO
1Lt Ryan Jodoi, B-1B Student Pilot
1Lt Robert Stinson, B-1B Student WSO
28th Bomb Squadron
7th Bomb Wing
Dyess AFB, Texas

TSgt James T. Jennings
Pneudraulic Craftsman
57th Component Maintenance Squadron
57th Wing
Nellis AFB, Nev.

SSgt David S. Mendenhall
Stockpile Surveillance Inspector
509th Munitions Squadron
509th Bomb Wing
Whiteman AFB, Mo.

SrA Matthew P. Bruce
Computer, Network, Switching, & Crypto Technician
9th Aircraft Maintenance Squadron
9th Reconnaissance Wing
Beale AFB, Calif.

Col David H. Sammons, Navigator
Maj Leo D. Cissell, Pilot
Capt David M. Kendall, Pilot
1Lt Joseph M. Kreykes, Pilot
Capt Deborah A. Mitchusson, Navigator
MSgt Scott A. Beavers, Flt Engineer
MSgt Joe A. Saxton
Airborne Maint Technician,
43rd Electronic Combat Squadron
55th Wing
Davis-Monthan AFB, Ariz.

Maj Kevin M. Dydyk
F-16 Pilot
421st Fighter Squadron
388th Fighter Wing
Hill AFB, Utah

FY06 Aircraft

As of April 30, 2006

	Fatal	Aircraft Destroyed	Aircraft Damaged
8 AF			
9 AF			**
12 AF			
AWFC		**	** **
ANG			
AFRC			

FY06 Ground

As of April 30, 2006

	Fatal	Class A	Class B
8 AF		1	4
9 AF		3	2
12 AF		4	1
ORU's		1	1

= Fatal = Fatal due to misconduct

FY06 Weapons

As of April 30, 2006

	Class A	Class B
8 AF	0	0
9 AF	0	0
12 AF	0	0
AWFC	0	0

Aircraft Notes

April was a busy month for mishaps. ACC had three Class As and again we got lucky with NO fatalities. We lost an F-16 following a GLOC, and trashed an engine with a birdstrike. We also had an F-15 suck up a gear pin during ground ops ... Ouch! From the host of other smaller mishaps, several things come to mind. First, ACC averages about one midair or near midair every 12 to 18 months. That's something worth briefing up again at your unit. Second, birds are on the move in the spring and fall, but it pays to be ready for that lone bird in the summer that decides to dive down your engine or fly through your canopy! There are tools to help you out. BAM models and AHAS real time NEXRAD www.usahas.com are worth a look.

Ground Notes

There have been no Class A mishaps for the past 2 months. However, Class B mishaps have jumped to eight so far this year. There were no Class Bs for the same time period in FY 05. The Class B mishaps have included four permanent partial disabilities and four property damage mishaps.

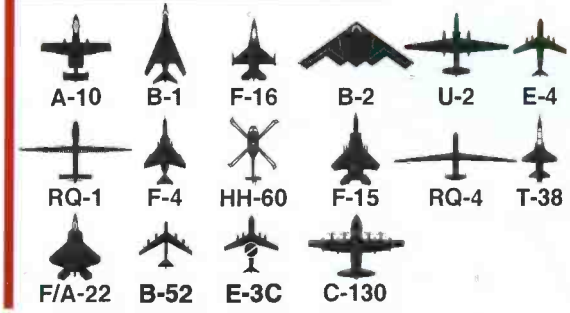
Weapons Notes

All of your hard work has paid off. ACC experienced only one reportable mishap for April. Good job by all!! Please continue to send out important safety information to your units and persist in your vigilance in spot inspections.

Legend

Class A - 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
*Non-rate Producing

Symbols for Mishap Aircraft




Fleagle
WHY ALL TH' STUFF?
IT'S FOR OUR DAY ON TH' WATER.
HOP IN TH' BOAT AN' I'LL PASS IT DOWN.
I'VE MADE SURE WE GOT PLENTY OF EVERYTHING.
BUT FLEAGLE...
USS LEAKSALOT
WE GOT FOOD, LOTS OF BAIT, RADIO, DRINKS, COLD WATER AN' BEER, TACKLE BOX, EXTRA RODS, COATS...
BUT FLEAGLE...
LANTERN, FLARES, FIRST-AID KIT, ICE BOX, EXTRA ANCHOR, SHOES, SEASICK STUFF, TOWELS, SUN SCREEN...
FLEAGLE!!
WHAT..?
WE GONNA NEED A BIGGER BOAT.
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HARRISON

Portable Generator Hazards

Portable generators are useful when temporary or remote electric power is needed, but they can be hazardous. The primary hazards to avoid when using them are carbon monoxide poisoning, electric shock or electrocution, and fire.

The United States Fire Administration (USFA) would like you to know that there are simple steps you can take to prevent the loss of life and property resulting from improper use of portable generators.

To Avoid Carbon Monoxide Hazards:

- Always use generators outdoors, away from doors, windows and vents.
- NEVER use generators in homes, garages, basements, crawl spaces, or other enclosed or partially enclosed areas, even with ventilation.
- Follow manufacturer's instructions.
- Install battery-operated or plug-in (with battery backup) carbon monoxide (CO) alarms in your home, following manufacturer's instructions.
- Test CO alarms often and replace batteries when needed.

To Avoid Electrical Hazards:

- Keep the generator dry. Operate on a dry surface under an open, canopy-like structure.
- Dry your hands before touching the generator.
- Plug appliances directly into generator or use a heavy-duty outdoor-rated extension cord. Make sure entire extension cord is free of cuts or tears and the plug has all 3 prongs, especially a grounding pin.
- NEVER plug the generator into a wall outlet. This practice, known as backfeeding, can cause an electrocution risk to utility workers and others served by the same utility transformer.
- If necessary to connect generator to house wiring to power appliances, have a qualified electrician install appropriate equipment. Or, your utility company may be able to install an appropriate transfer switch.

To Avoid Fire Hazards:

- Before refueling the generator, turn it off and let it cool. Fuel spilled on hot engine parts could ignite.
- Always store fuel outside of living areas in properly labeled, non-glass containers.
- Store fuel away from any fuel-burning appliance.

For more information on how you can protect yourself from the threat of fire during or after a disaster, visit the United States Fire Administration web site at: http://www.usfa.fema.gov/safety/tips/disaster.shtm

(Reprinted courtesy of the United States Fire Administration)