

# Combat Edge

September 2006

*Air Combat Command's Safety Magazine*

**COMBATTING**  
**COMPLACENCY**  
**ON AND OFF DUTY**

combating complacency on and off duty  
**WEAPONS**  
**TRENDING**





# Combat Edge

Volume 15 Issue 4, ACC SP 91-1



GENERAL RONALD E. KEYS, COMMANDER  
COLONEL CREID K. JOHNSON, DIRECTOR OF SAFETY

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LT COL ANTON KOMATZ  
EXECUTIVE EDITOR

MAJ DANIELLE COLEMAN  
EDITOR

MRS. BARBARA TAYLOR  
ASSOCIATE EDITOR

TSgt AMBER JORDAN-BALOY  
PUBLICATIONS DESIGNER

SSgt SAMUEL ROGERS  
ASSOCIATE PHOTO EDITOR  
1<sup>ST</sup> COMMUNICATIONS SQUADRON

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**CONTRIBUTIONS:** PLEASE SEND ARTICLES  
WITH NAME, RANK, DSN PHONE NUMBER,  
E-MAIL AND COMPLETE MAILING ADDRESS  
AND COMMENTS TO:

EXECUTIVE EDITOR, **THE COMBAT EDGE**  
HQ ACC/SEM  
175 SWEENEY BLVD  
LANGLEY AFB VA 23665-2700

**TELEPHONE:** (757) 764-8868  
DSN 574-8868  
**FAX:** (757) 764-8975  
**E-MAIL:** ACC.SEM@LANGLEY.AF.MIL

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**M** OR **M** = MANIPULATED IMAGE

# ACCent ON SAFETY

## *It's Easy Being Safe ... All it takes is a Little Common Sense*

As I join the ACC Safety Team, I'm looking forward to working both with and for you to help preserve and enhance our combat capability. Safety is an integral component in preserving and enhancing that capability, and I firmly believe that safety takes a human, personal touch. It's not a computer program that's managed, but a personal commitment and connection aimed at fostering safety values.

We all know it's easy to be safe; it just takes some common sense. But where did our common sense come from, how was it developed, did it come from the same source, and do we all place the same value on it?

How many times have you heard or uttered the phrases, "If you just used a little common sense, none of this would've happened ...," "He just lacks common sense," or a parent's favorite, "If you had just used an ounce of common sense." I know I've said it, or thought it many times, especially when I hear of someone getting hurt or killed by doing something blatantly dangerous. People aren't born with common sense, you can't really buy it. If it's so common, why do some people lack it, or only gain it through trial, error, and pain?

What we refer to as common sense is really knowledge or opinion that reasonable people would agree is just good, solid judgment. Common sense is learned behavior and knowledge that we first learn from our parents and family, and then from school and others as we get older. As Air Force Airmen, it becomes knowledge gained through education, training, and experience that allows us to complete the mission and do it safely. When learned and applied correctly, common sense can be a powerful ally.

This issue has several articles dealing with complacency and distractions, our two biggest threats to common sense, while others highlight the effectiveness of risk management, training, and experience; all key components of common sense. Remember, if someone is lacking the knowledge we call "common sense," you can learn it, share it, and pass it on. Let's all make a personal commitment to foster good safety values and share a little common sense.



Lt Col Kelly E. Fletcher,  
Chief of Flight Safety





# Weapons *Trending*

*by Capt Allen D. Boettcher, Barksdale AFB, La.*





**T**his article is intended to focus on some trending issues in the weapons safety arena. Even though the focus is primarily on weapons safety, some of the ideas can be applied to flight and ground safety. The commonly used Webster's Dictionary (1984) defines a trend as a "*general indication of tendency, drift, or a direction of movement.*" The dilemma in weapons safety is that Weapons Safety Managers (WSMs) sometimes have a difficult time discovering new trends due to the lack of mishaps. Now, this is a dilemma that most people would like to experience, but with the lack

of mishaps, sometimes what occurs is a false sense of security. This false sense of security happens when a unit goes 4 or 5 years without a mishap. The mindset becomes, "How can we possibly improve upon our perfection?" Just because a unit does not have any reportable mishaps under the criteria presented in AFI 91-204, doesn't mean mishaps are not occurring, or nearly occurring. For instance, a Dull Sword that involves personnel is a form of a mishap. A vehicle accident in the missile or weapons storage areas is a mishap. None of these examples are reportable as "weapons mishaps," but they are mishaps nonetheless. There are many avenues in





which to gather traceable data, some of which are discussed near the end of this article.

Accuracy in the gathering and categorizing of measurable data is probably the most important aspect of new trending. Some of the more common errors seen in the originating data are that the data is not accurate or there are variables that have not been factored into the equation. One of the biggest mistakes I have witnessed in my 3 years as a WSM is the improper categorization of a mishap. There is specific guidance in AFI 91-204, including examples that clarify these categorizations (p. 9-13). This improper classification skews the data rather than having all like-industrial weapons events in Air Force Safety Automation System where they can be consolidated, accessed, and evaluated.

***“One of the biggest mistakes I have witnessed in my 3 years as a WSM is the improper categorization of a mishap.”***

Another big factor regarding accuracy is how long the data has been collected. Data collected over the span of years seems to be somewhat more accurate than data over the short-term. This can be important in regards to spikes that occur. A lot of times when short-term data is analyzed, a spike may appear to be a world-changing event, when in reality it is nothing more than a natural occurrence. The stock market is a good example of the various types of data collection. If an investor looks at the day-to-day results, they will probably invest differently than those who look at the 5-, 10- or 20-year data.

The final problem dealing with accuracy is the defining of the variables and to what level of attention does the trend require for resolution.





Photo by A1C Cecil McCloud

One or two time incidents of perception are not considered a trend, nor is a spike considered a trend.

In AFI 91-202 the first sentence of paragraph 5.5 states: *"full time Safety staffs at all levels should develop locally oriented mishap analy-*

*sis programs to evaluate mishap statistics and identify trends (p. 25)."* Mishap statistics are the key. Be sure to have all the facts prior to releasing the data.

The solution for accurate trending is to keep it simple. The easiest way to do that is: keep your variables constant, and do not allow them to have any flexibility. A couple of examples might be to use clock times rather than terms: 1800 to 0600 rather than dusk or after dark. Another variable might be the use of days: Monday, Tuesday, Wednesday, etc. These variables do not adjust and do not require a mathematical formulation for accuracy.

Within 8 AF, the Weapons Safety community has gone 4 years without a reportable mishap. This is a good thing, but being part of the AMMO world for over 22 years, I know that accidents or near misses

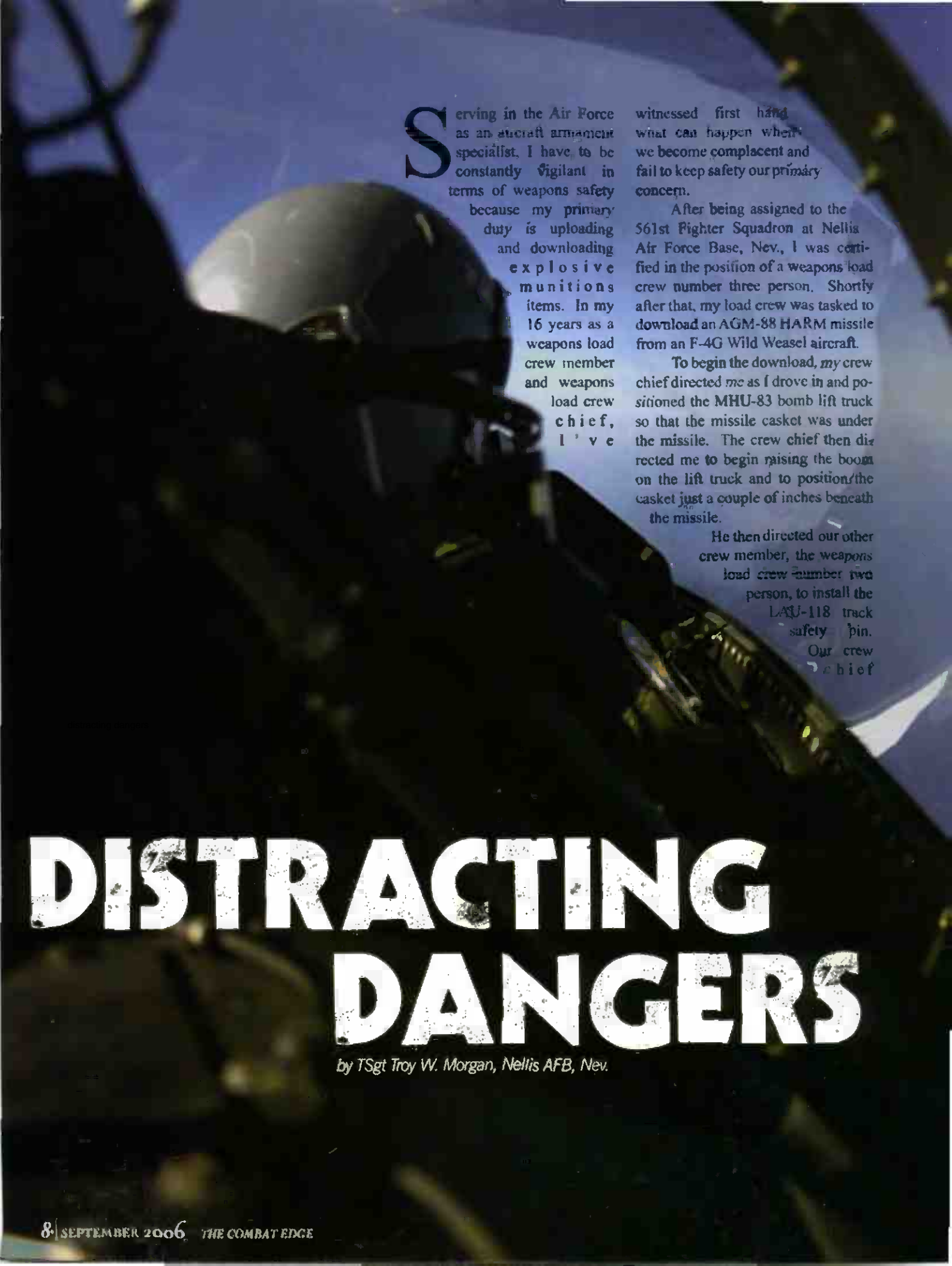
happen daily. It is the nature of the business; moving large numbers of munitions and heavy equipment results in smashed fingers and stubbed toes. But the dilemma is in answering the question of: how do we measure these incidents in order to prevent the big one?

Statistical trending is a very important aspect in the safety business. What this article is intended to do is present different ways for a WSM to become creative in researching their trends. Looking at figures and getting a grasp on a possible trend that is accurate and acceptable, and I hope this article has enlightened the reader on some of the challenges involved with trending. As ACC has stated in their ACC Crosstell, June 2005, "effective trending and analysis is more than a scoreboard of occurrences; properly accomplished it is a strong mishap prevention tool." ✈



Photo by A1C Anthony Nelson, Jr.





**S**erving in the Air Force as an aircraft armament specialist, I have to be constantly vigilant in terms of weapons safety because my primary duty is uploading and downloading explosive munitions items. In my 16 years as a weapons load crew member and weapons load crew chief, I've

witnessed first hand what can happen when we become complacent and fail to keep safety our primary concern.

After being assigned to the 561st Fighter Squadron at Nellis Air Force Base, Nev., I was certified in the position of a weapons load crew number three person. Shortly after that, my load crew was tasked to download an AGM-88 HARM missile from an F-4G Wild Weasel aircraft.

To begin the download, my crew chief directed me as I drove in and positioned the MHU-83 bomb lift truck so that the missile casket was under the missile. The crew chief then directed me to begin raising the boom on the lift truck and to position the casket just a couple of inches beneath the missile.

He then directed our other crew member, the weapons load crew number two person, to install the LAU-118 track safety pin. Our crew chief

# DISTRACTING DANGERS

by TSgt Troy W. Morgan, Nellis AFB, Nev.



then positioned himself over the casket and missile and the number two person took his position behind him. Together, they bent over and wrapped their hands around the missile. They began to manually lift up and pull back at the same time, sliding the missile off. The missile slid back and then stopped. They repositioned their hands further down the missile body. After one last lift and pull, the missile slid back and instantly fell through the hands of both the crew chief and the number two person, landing hard in the casket. All three of us looked at each other in scared amazement.

That was not supposed to have happened. The missile should have slid back until it was stopped by the track safety pin. I should have then raised the casket up until the missile securely rested in it.

Immediately, the crew chief asked the number two person where the track safety pin was and why he hadn't installed it when the crew chief had directed him to. The number two person told the crew chief that he never told him to install the track safety pin. The crew chief then asked me if I had heard him tell the number two person to install the track safety pin. Unfortunately, I had not been paying attention and had been distracted by other things on the flight line. The crew chief called our expeditor over and briefed him on what had just happened and then notified wing weapons safety.

In hindsight, there were a couple of human factors that



Photo by MSgt Edward Snyder

*"Luckily, no one got hurt that day,  
but it could have been very different."*

came into play that day and may have contributed to this incident. Our crew chief had been going through a divorce and lengthy custody battle for his two daughters. He had also told us once our duty shift started that he had only gotten 3 hours of sleep the night before.

Another factor was that we were in the 11th hour of our shift so fatigue and complacency were definitely part of the equation. The number two person was not familiar enough with the track safety pin procedure and did not hear the crew chief. The crew chief should have visually verified that the track safety pin had been installed, but failed to do so. Finally, if I had been paying close attention to the download operation and not

been distracted, I would have seen that the number two person had not heard the crew chief.

As a whole, all of us were not focused on the task at hand. Luckily, no one got hurt that day, but it could have been very different. Had the number two person and crew chief interlocked their hands under the missile body, the weight of the missile could very easily have broken both their arms. Any one of us could have prevented this mishap if we had not been distracted by other things. It is imperative that we all maintain safety awareness in our daily operations up until the end of our shifts. This is a must if we all want to go home in one piece at the end of the day.



# COMPLACENCY = MISHAP

by MSgt Edward L. Story, Jr., Cannon AFB, N.M.



Photo by SSgt Michael Holtzworth

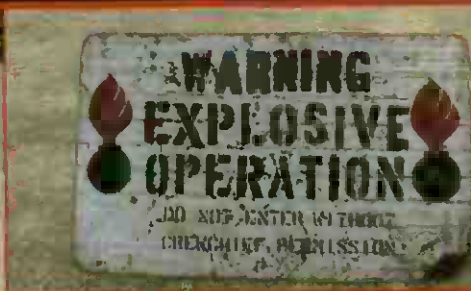


Photo by TSgt Robert J. Horstman



Photo by A1C Angela Ruiz

Throughout the aircraft maintenance community, weapons mishaps occasionally occur due to complacency. During my 18 years as an aircraft armament systems specialist (also known as a weapons troop or loader), I have witnessed several of my peers, to include myself, fall victim of a safety mishap directly resulting from becoming too complacent on the job.

Unfortunately, when a mishap takes place, there are certain emergency action procedures immediately initiated to verify the seriousness of the incident. The focus usually turns to the individuals who silently question themselves. How could I/we have made that mistake? What could I/we have done better? How will I/we be looked upon by our organization? And sometimes the question that looms

the largest is: What type of administrative action can I/we expect? Often the individuals involved feel a sense of failure and regret.

The positive aspect of the mishap investigation is that it affords us all the opportunity to learn from the mistakes that were made and make the corrections necessary to ensure they don't happen again. This is what safety professionals call mishap prevention.

After many years of faithful service working in aircraft maintenance on the flight line, my career shifted when I trained to assume the role of a Weapons Safety Manager (WSM) for my fighter wing. As the WSM, I was tasked to perform a variety of duties. This included the tough task of finding out the cause of a mishap and providing recommendations in order to pre-

vent reoccurrences. While this part of the job often got me tagged as the "bad guy," it broadened my perspective on the things that can contribute to a mishap.

One of the biggest factors I found was complacency. I heard it over and over again in the initial responses from interviews with or statements from individuals involved in a particular mishap I was investigating. They included: "I took for granted ..." or "I thought he or she did it ..." or, better yet, "I assumed it had been accomplished." These statements reflect how easily complacency can sneak into our workday.

Another cause of complacency comes from the exceptional performers with the "I have been doing this for years" syndrome. This way of thinking is generated from the repetition





Photo by SPC Brandi Marshall

*"I took for granted ..."*

*"I thought he or she did it..."*

*"I assumed it had been accomplished ..."*

involved in some jobs. When a task is done over and over again, people tend to stop following the technical data because of their familiarity with the procedures. None of us are so proficient that we can work without checking the guidelines provided. When we do this, we set ourselves and others up for failure, possibly placing everyone in physical jeopardy.

Complacency starts and ends with each of us. We must immediately recognize when it starts to creep into our thinking and actions on the job. Then we must find ways to eliminate it if we are going to reduce the risks associated with our professions. This is the critical first step to get us all on the road to mishap prevention. ✱



Photo by SSgt Lance McNeal





Normally, the only thing I get out of an 8-hour Supervisor of Flying (SOF) tour is a negative attitude and the loss of feeling in both my legs. However, at a place like Balad, with a few takeoffs and landings during the midnight SOF tour, there is no shortage of adventure. Between keeping up with the ever-changing weather and Notice to Airmen, plotting mortar impacts, and keeping the airfield free of foreign objects, there is precious little time for relaxation.

The night of January 24, 2006, was no different than "usual" in most respects. The weather was Visual Flight

Rules (VFR) from Greece to Pakistan, the winds were light and variable, and there were two flights of F-16s airborne. During the hand-off from the previous SOF, I was told that "there was absolutely nothing going on." This was my third week in theater and my fourth SOF tour, and up until then, things had been relatively smooth.

At approximately 0130 local, I received the following radio call: "Red Tail SOF, THUD 81 is overhead the field with a B-system hydraulic failure and the Emergency Power Unit (EPU) is running." I immediately opened my emergency action checklist, as well as

my Block 30 Dash 1 checklist; and because he said the "EPU word," I notified the tower supervisor who activated the crash net. Not being current and qualified in a Block 30, I called THUD's Top 3 and followed along as they ran the checklist with the emergency aircraft. As they analyzed the full extent of the Emergency Procedure (EP), they concluded that he had a Power Takeoff (PTO) Shaft failure.

On a "good/bad scale," a PTO shaft failure in the F-16 is really bad, as it connects the engine gearbox to the Accessory Drive Gearbox (ADG), which powers the main and standby generators.



# Combat SOF

by Capt James Busch, Hill AFB, Utah

Photos by A1C Brian J. Ellis



systems A and B hydraulic pumps, and the flight control system Permanent Magnet Generator, known as the "FLCS PMG" which provides primary power for the flight control system. In the Viper, that's pretty much everything. At this point, THUD 81's EPU was supplying all of the electrical and hydraulic power to keep the jet flying, putting him in a "land as soon as possible" situation. The situation also necessitated the need for an alternate gear extension, as well as an approach-end cable arrestment landing with degraded flight controls. The PTO failure also meant the loss of the pilot's usual Heads Up Display (HUD),

Angle of Attack (AOA), and command steering symbology used during landing. Further complicating matters was the fact that once on the ground, the pilot would have limited directional control of the aircraft, because the F-16 loses nose wheel steering when an alternate gear extension is performed, and with no B-system hydraulics, the pilot would have, at best, 70 seconds of accumulator braking at his disposal in order to stop the jet.

Both of the runways at Balad AB are old, and in constant need of repair. Case in point: an F-16 had missed the departure-end cable because of the

unevenness of the runway surface the week prior. Instead of relying on the accumulator braking being sufficient with the departure-end cable as a backup in case the aircraft couldn't be stopped, we all (Top 3, SOF, and pilot) agreed that an approach-end arrestment would be the safest plan, with a go-around option if the hook missed the cable. I coordinated for THUD 81 to fly an opposite direction approach to runway 32 and take the approach-end cable, with THUD 82 executing a low approach and landing normally on Runway 12. I notified the Operations Group Commander (OG/CC) on the





*"Time was critical and our options suddenly became severely limited."*

plan, while the tower supervisor expertly coordinated with airfield ops, crash rescue, THUD 81, and other inbound aircraft. All players referenced their emergency action checklists to ensure no details were overlooked, and once all the pieces were in place, we were prepared to execute the plan.

At this point, less than 5 minutes had passed, and we were feeling pretty much on top of the situation, when at 0135 local, all the runway lights suddenly went out. With seconds to go, instead of looking at two well-lit runways on approach, THUD flight was suddenly looking into a black hole. Time was critical and our options suddenly became severely limited. THUD flight's two closest divers were still 50 miles away and the landing strip had no cables, and the closest airfield with a cable was over 100 NM away. Also complicating

matters was fuel. THUD 82 would not make it the 100 miles to the divert base and then back to Balad; but more importantly, if THUD 81 ran out of EPU fuel, he would have to eject. I immediately came to the conclusion that Thud flight had to land at Balad, and soon. To facilitate this, I called for the airfield operations vehicles to illuminate the approach-end cable with their headlights. Additionally, THUD 82 would "sparkle" the approach-end of the runway with his Infra-Red (IR) pointer, allowing THUD 81 to fly an NVG approach and landing, which is something we do not normally do in the Viper world. THUD 81 agreed to the plan, and while I coordinated with the OG/CC, THUD ops coordinated for a tanker for THUD 82, allowing him to perform a low approach and hold over the field once THUD 81 landed.

Once the OG/CC gave permission

to proceed with the plan, every vehicle on the airfield rushed to the approach-end of Runway 32 to take part in "Operation Cable Illumination." The traffic rushing to the scene created an illusion for THUD 81 on his first landing attempt, forcing a go-around. With two vehicles already on each side of the runway illuminating the cable, I instructed all other vehicles on the airfield to stop and turn their lights off. On the second try, THUD 81 made a flawless NVG approach and landing and successfully engaged the approach-end cable.

With THUD 81 safely on the ground, my attention turned to THUD 82, who was now in a low fuel situation. With less than 15 minutes of fuel remaining and the tanker over 80 miles away, and in the opposite direction of his closest divert field, I advised him to disregard the tanker and head for his



closest divert field. THUD 82 landed uneventfully at the divert field, refueled, and returned to Balad AB later that morning.

With everyone safely on the ground, we all breathed a sigh of relief. We had faced a dynamic situation not covered by our checklists, had made split-second decisions, and gotten everyone back safely. Several factors worked in our favor. Although not current and qualified in the Block 30 F-16, I was trained and qualified, and had the experience to know to call the Top 3, and then apply my knowledge, experience, and leadership as the OG/CC's "eyes on the ground" where applicable to bring the situation to a successful conclusion.

Whether we realized it or not, we all used Operational Risk Management to our advantage to bring the situation to a

successful ending once the lights failed at Balad. One thing we (SOF, Top 3, pilots, and commanders) did right (once the airfield lights failed) is that we took all factors into consideration (divert bases, distances, tankers, and EPU fuel status) and didn't make any decisions or take any actions that limited our options or "painted us into a corner." Diverting THUD 81 may seem like the "safe," or conservative choice; however, for that plan to be successful, three separate scenarios would have to take place: the EPU would have to remain operable, the EP would have to remain stable, and the pilot would have to make a successful landing under less favorable conditions (cable landing systems). Additionally, delaying THUD 82's divert, or making the decision to chase the tanker would have put considerable pressure on the

pilot to make a successful rendezvous and then for all of the refueling systems to operate properly; placing all of our eggs, and the safety of pilot and aircraft in one basket.

Other factors that played to our advantage were the presence of VFR weather and light winds, which enabled THUD 81 to perform an opposite direction approach. The tower crew was nearing the end of their tour at Balad and was experienced and familiar with the local flying environment. Especially since we were all new to Balad, the competence and experience of the pilots, Top 3, the SOF all contributed to the termination of a successful EP, but it was everyone's ability to think on their feet, communicate, and execute that saved the day. ■

*"With everyone safely on the ground, we all breathed a sigh of relief."*





# SCHOOL BELLS

*School bells are ringing, and children are flocking to school — in buses, on bicycles and on foot. That adds up to extra hazards for motorists.*



Photo by Mr. E. Todd, Virginian-Pilot



**S**low down while driving through school zones. If you speed, you may not see children walking behind bushes or parked cars. Also, children's depth perceptions are not fully developed until they are 9 years old, so they can't accurately judge the distance or speed of your car. Their attention spans are short, so they may dart into the road unpredictably. Watch for crossing guards and children when making a right turn on red. Speaking of crossing guards, treat them with the respect you'd show a member of your state's highway patrol. Obey their direction because they are the law.

In school areas, drive as closely as possible to the center line on a two way street to put as much room as you can between your car and the sidewalk or roadside. That way, even if a child unexpectedly tumbles off a bicycle, you are far enough away to react in time.

If you need to sound your horn as a warning, don't blast it continually. A loud noise behind children can scare them into unpredictable dashes. A light tap on the horn is sufficient to let a child know you are there.

Turning on your headlights while driving through school areas will also help kids see you coming.

Use extreme caution around buses. Know what the light signals on buses mean in your area, and know how far away you're required to stop. Be careful about taking off immediately after the lights go out, since children often dash to catch the bus before it pulls away. Do not pass a school bus when its stop signal is displayed.

Be alert and patient. The risk of having a traffic mishap increases at the end of the day. Drivers are tired after a long day at work, while children are excited to be out of school.

Keep your temper in check at all times and watch out for the children, our future depends upon it.





by Perry V. Mitchell, Sr., Tyndall AFB, Fla.

# DRIVING COMPLACENCY



**W**e are all guilty of complacent driving. What is it? Our daily routine usually starts out the same way. Hit the snooze button a couple times to get those 8-minute cat naps in before jumping up and running out the door. We jump in the vehicle without performing a cursory vehicle check to see if the tires are still round. We throw the coffee mug on the dash or in the special made holder, start the car, and go!

Pull out of the driveway onto the parkway and, zoom; we are off for another great day. We do our quick California stop at the stop sign, speed through the yellow lights, and swerve in and out of traffic in hopes to beat the other fellow. As we're driving, our minds are already thinking of the 10 meetings, 12 phone calls, and 2 briefings we have planned for the day.

Did you think about the road conditions? Is it sunny, rainy, foggy, or at the right temperature to develop the dreaded black ice you can never see? Are there wet leaves on the ground to slip/slide you through the intersection? Is traffic flow going a good pace and

how much distance is there between you and the vehicle in front of you, or is your mind still on the late meeting you have in the afternoon? Oh, and how many times did you answer or make a call on the cell phone to distract you to the point of almost hitting the vehicle in front of you because you didn't see the non-working brake lights?

What did we all do? We did the same thing we did yesterday and the day before that. We rushed to the vehicle without taking a few extra minutes to perform a short walk around to inspect for "readiness." We failed to ensure all lights (turn signals, head and tail lights) are in proper working order. How do the tires look? Can you tell they have the proper inflation just from walking around it? What about the smudge mark on the inside of the windshield you've been meaning to clean for the past 2 weeks? When was the last time you were running late and scraped off just enough frost from the windshield to see out of and let the car defroster clear the windshield while you were driving; if you have, what didn't you see because you were playing "Sub Commander?"

The only way we can overcome the tendency to become complacent is by keeping our heads in the driving game. Many of us take driving for granted because we've been doing it for so long. The next time you're behind the wheel, take the time to notice how far ahead into traffic you're looking. Is there new construction ahead? Or an accident, a person walking, jogging, or riding a bicycle that may create a hazard? When you approach an intersection are you calculating your speed and distance to the traffic light and if you have time to stop if it turns yellow/red?

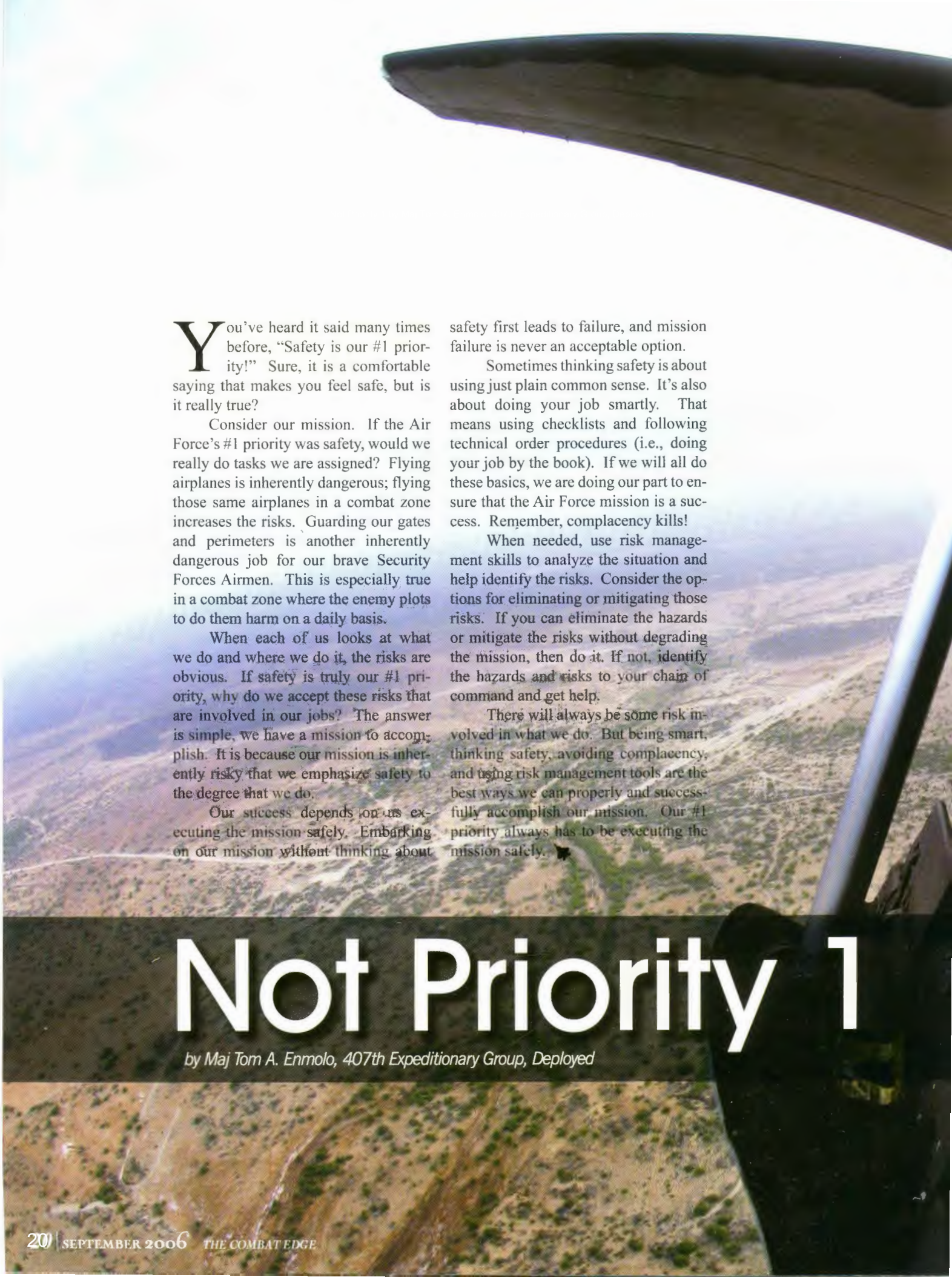
Here's a good question: How many drivers know what's coming up behind them if they have to perform an evasive maneuver or stop quickly? Do you look in the rearview mirror to see if you are in danger from being rear ended? Will you have time to get out of their way after you hear the tires screeching to a stop?

We all have distractions in life, but thinking about driving and driving conditions could just make the difference between a close call and a bad hair day! ➤



Photo by S/A Joseph Thompson





**Y**ou've heard it said many times before, "Safety is our #1 priority!" Sure, it is a comfortable saying that makes you feel safe, but is it really true?

Consider our mission. If the Air Force's #1 priority was safety, would we really do tasks we are assigned? Flying airplanes is inherently dangerous; flying those same airplanes in a combat zone increases the risks. Guarding our gates and perimeters is another inherently dangerous job for our brave Security Forces Airmen. This is especially true in a combat zone where the enemy plots to do them harm on a daily basis.

When each of us looks at what we do and where we do it, the risks are obvious. If safety is truly our #1 priority, why do we accept these risks that are involved in our jobs? The answer is simple, we have a mission to accomplish. It is because our mission is inherently risky that we emphasize safety to the degree that we do.

Our success depends on us executing the mission safely. Embarking on our mission without thinking about

safety first leads to failure, and mission failure is never an acceptable option.

Sometimes thinking safety is about using just plain common sense. It's also about doing your job smartly. That means using checklists and following technical order procedures (i.e., doing your job by the book). If we will all do these basics, we are doing our part to ensure that the Air Force mission is a success. Remember, complacency kills!

When needed, use risk management skills to analyze the situation and help identify the risks. Consider the options for eliminating or mitigating those risks. If you can eliminate the hazards or mitigate the risks without degrading the mission, then do it. If not, identify the hazards and risks to your chain of command and get help.

There will always be some risk involved in what we do. But being smart, thinking safety, avoiding complacency, and using risk management tools are the best ways we can properly and successfully accomplish our mission. Our #1 priority always has to be executing the mission safely. ✦

# Not Priority 1

*by Maj Tom A. Enmolo, 407th Expeditionary Group, Deployed*











# You've met me BEFORE

*Reprinted courtesy of the Red Tail Flyer*



**Y**ou've met me before. At first, I can seem like a real nice guy. I tell you to ignore the checklist, rules, and tech orders. You like this because it makes your life much easier. I ask you, "Why put that seat belt on? It takes too much time." Or I tell you, "Forget about the speed limit ... you are a better driver than anybody else." I'm proud of my accomplishments — read what I have done to some of your fellow Airmen.

Lt Col X was finishing his AEF tour. He took off in his mighty F-16, ready to battle the enemy and didn't notice the weather rolling into the base. After 2 hours in the sky, Lt Col X decided to return to base. He was low on fuel but still had some options. He flew his first approach to the base, but due to bad weather he was unable to acquire the runway for landing. Lt Col X executed a missed approach. He was getting really low on fuel and I convinced him not to divert. He listened to my advice and





Photo by SSgt Cherie A. Thurlby



Photo by SrA Brian Ferguson



Photo by SrA John Taylor

decided to try another approach. Once again, he was unable to find the runway. Now, Lt Col X was very low on fuel and out of options. On his third and last approach he panicked and landed fast and long down the runway. He couldn't stop the jet and ended 600 feet off the end of the runway. I caused about \$100,000 worth of damage and I almost got him.

Tech Sgt Y was doing some work on top of a Hardened Aircraft Shelter (HAS). The top of the HAS is about 30 feet up, but he didn't mind; heights don't bother him much. I told Tech Sgt Y to forget about the safety harness and he listened. First, he used a rope to climb up the HAS. Upon reaching the top of the HAS, he proceeded to do his work — without a safety harness. After finishing the job, Tech Sgt Y used the rope to climb back down. Halfway down, he slipped and fell 15 feet to the ground. Tech Sgt Y was treated for a shattered left heel bone, a compound fracture of the right elbow, and several bumps and bruises. I almost killed him too.

I met Lt Z only 9 days after she gave birth to her second child. Lt Z was driving her car home after dropping her toddler off at the Child Development

Center. Her husband was at home watching their newborn. Lt Z was exhausted because she had been up all night watching the baby. She had her seat belt on; I tried to convince her otherwise, but she didn't listen. I figured another tactic would have to work. As Lt Z rounded a corner, I convinced her to look down and fiddle with the radio. She did this, and the next thing Lt Z saw was a concrete wall. She had no time to react, and I got her.

Trust me, as AEF 9/10 concludes, you will see more of me. It's human nature to get lazy after 4 months in a combat zone. I will take advantage of this and will do everything in my power to ruin your tour. I will try to make you ignore the checklist, break the rules, and ignore tech order guidance. And once you get home from your deployment, I will continue my efforts to ruin your life. I will convince you that it is OK to drive drunk, fast, and without a seat belt. I will convince you to let your guard down, slowly but surely, and when I succeed, you lose.

My name is complacency, and if you listen to me, I will kill you! ✖

***"I almost killed him, too."***



Photo by A1C Melissa Flores





**SAFETY 06-02**

Date/Time: 1 Jun 06/1100

## Questions?

Contact your  
functional POC at ACC or the  
ACC LSET:

Lt Col Kevin Fitch  
OR  
MSgt Andy Lipko

DSN: 575-4305  
574-2936

# ACC LSET FLASH

## F110 Magnetic Chip Detector (MCD) Inspection Procedures

### Issue:

Emphasize that all Transit Alert (TA) contract personnel are performing MCD inspection on F-16 aircraft with F110 installed engine. T.O. 1F-16C/CG/CJ-6-11 Launch and Recovery/Alert Recovery Inspection mandates the use of a 10X magnifying glass to inspect the MCD prior to Scanning Electron Microscope/Energy Dispersive X-Ray (SEM/EDX) analysis on the F110 engine. At non SEM/EDX equipped bases as a minimum, 10X magnifying glass inspections method must be performed for detecting impending bearing failures. Failure to make an adequate inspection may result in severe engine damage.

### Emphasis Required

- The 10X magnifying glass inspection must be accomplished on every launch and recovery/alert recovery inspection.
- Ensure TA personnel are properly following and/or interpreting technical data regarding (SEM/EDX) and 10X magnifying glass inspections related to the F110 engine.

### Distribution: **ACC MXG Commanders** **ACC/A4 Divisions** **ACC/A4**

ACC LSET Flash messages are sent to ACC/MXG and MSG commanders to quickly get the word out on safety issues and/or significant adverse trends that are identified by LSET. Flash messages are intended to provide timely notification to the field on issues that need immediate leadership emphasis and will be in one of three categories: Safety, Maintenance, and Logistics. They do not, however, negate the need for units to review LSET reports. Flash messages are also posted on the LSET web site.



# MONTHLY AWARD WINNERS

## **Flight Line Safety** Award of Distinction

**S** Sgt Alford was training SSgt Redig on how to properly inspect, remove, and replace the Structural Mode Control Vane (SMCV), as well as accomplish TCTO 1289, a complete rebuild of the Structural Mode Control System on the B-1 aircraft during a phase inspection. Sgts Alford and Redig conducted an initial inspection of the SMCV surface and noticed that the right side SMCV had a 3/4 inch gap between the SMCV and the aircraft fuselage. To investigate further, they removed the right SMCV access panel in the nose wheel well. SSgt Alford immediately noticed the right SMCV locking washer was not seated into the nut grooves and the nut had backed off to within two threads of coming off completely. The collar, which holds the entire assembly together was not fully tightened either. In this condition, the right SMCV was only one or two flights from failing. This would have resulted in catastrophic failure of the system and the vane to depart the aircraft. They also inspected the left SMCV and found the following discrepancies; the locking washer was not seated, the actuator did not have a cotter key pin, and the nut was loose and close to falling off. SSgt Alford and SSgt Redig im-

mediately notified their supervisor; TSgt Charles P. Abt, who advised them to take pictures and notify Maintenance Supervision, Quality Assurance, and CAMS Data Analysis section to research all maintenance history on the SMCV system and to verify if the aircraft had received TCTO 1320. Additionally, they completed the Wing Flight Safety Office Hazardous Accident Potential (HAP) report. After discovering that TCTO 1320 had been completed in January 2006, SSgt Alford and TSgt Abt believed there could be a problem with TCTO 1320. SSgt Alford sent an e-mail, with pictures, to Quality Assurance and Wing Flight Safety as required by AFI 91-202 for HAP reporting. SSgt Alford and SSgt Redig's discovery and actions generated a random sampling inspection of six aircraft which revealed another B-1 with similar discrepancies and led to a one-time inspection of the entire B-1 bomber fleet.



**SSgt John H. Alford, SSgt Brian M. Redig**  
28th Maintenance Squadron  
28th Bomb Wing  
Ellsworth AFB, S.D.

## **Ground Safety** Award of Distinction

**S** rA James exemplifies the model squadron safety rep. Sheaced a recent 8AF/SE SAV, which identified her efforts as "second to none!" She manages the commander's safety program for a 519-person geographically dispersed squadron with work centers located on both Hickam AFB and at an underground joint facility 19 miles away at the National Security Agency/Central Security Service-Hawaii. She established a strong squadron high-risk activities program, educating all unit members and ensuring flight leadership maintains awareness of their members' off-duty high-risk activities. She processed over 1,500 high-risk activity forms, ensuring 100 percent accountability and documented acknowledgment of personal risk management responsibilities. Her newcomers' and pre-departure safety briefs received accolades during the 70th Intelligence Wing SAV, as the inspector commented, "This is what we want to see all units doing." Of note, during a recent squadron safety down day, she secured a local ocean tides expert to provide a water haz-

ard briefing applicable for the coasts of Oahu. This invaluable safety info proved hugely popular among squadron members, and has been incorporated into the newcomers' info. SrA James created a safety inspection checklist tailored for the unit's unique requirements and provided standardized guidance and training to safety reps across seven flights. She supports the commander's emphasis on a Wingman culture by: distributing Wingman "Don't Leave Home without It" cards to squadron members, providing 24-hour leadership and key personnel emergency contact info to include local AADD, sexual assault response, and Life Skills on-call phone numbers. SrA James reinvigorated the Motorcycle Mentor Program and promoted regular group rides around the island, and initiated semi-annual personal safety checks, resulting in zero motorcycle mishaps to date.



**SrA Angie M. James**  
324th Intelligence Squadron  
70th Intelligence Wing  
Hickam AFB, Hawaii



## Pilot Safety

Award of Distinction

An F-16 pilot (Brag 11) ejected over the Atlantic Ocean more than 35 NM off the coast. Upon ejection, Brag 12, Capt Simmons, immediately called a Knock-It-Off (KIO) on the working area's common frequency and set up as the on-scene commander for search and rescue operations. Lt Col Littleton, who was working the north part of the area as Dice 31, heard the KIO and proceeded south to assist. Dice 31 informed the area controller and Shaw's SOF that Brag 11 had ejected and requested a Coast Guard helicopter be scrambled to recover the downed pilot. Dice 31 also contacted Haze 21 flight to further assist in the rescue effort. Haze 21, Maj Schaare, departed his nearby working area and arrived over the crash site. Brag 12 maintained a low orbit over Brag 11; attempting to maintain visual contact while trying to establish communications with the downed pilot. Meanwhile, Dice 31 ensured altitude and radio frequency de-confliction for all search and rescue assets. Heavy sea conditions and the setting sun made it extremely difficult to maintain sight of Brag 11. Due to the extensive nature of his injuries, Brag 11 was unable to communicate with his squadron mates orbiting above. When fuel ran low, Brag 12 handed off on-scene commander duties to Dice 31. Dice 31 continued to search for Brag 11 in the water with limited success, and upon reaching Bingo fuel, passed the on-scene commander duties to Haze 21. Haze 21 continued the search until the Coast Guard rescue helicopter arrived. Haze 21 passed the last

known position of the survivor to the Coast Guard helicopter crew and provided a visual talk-on to the area where Brag 11 was last seen. A naval vessel (the *USS Klackring*) had intercepted the distress calls and headed for the search area at flank speed to assist. Haze 21 saw the ship and flew over the fantail twice while attempting to raise them on VHF Guard. When the commander of the *USS Klackring* responded, Haze 21 gave them the radio frequency the Coast Guard was using, as well as Brag 11's last known coordinates. Approaching Bingo fuel, Haze 21 flew over Brag 11's last known position and dropped flares, enabling the *Klackring* and Coast Guard helicopter to focus their search. Shortly after Haze 21 departed the area, *Klackring* spotted Brag 11. Brag 11 was taken aboard the *Klackring*, stabilized, and then flown by the Coast Guard helicopter to a nearby trauma center for emergency surgery. The exceptional actions, teamwork, and coordination between Capt Simmons, Lt Col Littleton, Maj Schaare, the Coast Guard, and the US Navy were instrumental in the successful rescue of Brag 11.



**Capt Craig Simmons, Maj Doug Schaare  
Lt Col Thomas Littleton  
55th Fighter Squadron  
20th Fighter Wing  
Shaw AFB, S.C.**

## Weapons Safety

Award of Distinction

While conducting weapons maintenance in the high bay of building 7710, TSgt Holmes, SSgt Farmer, and SSgt Kind detected a potential malfunctioning air handling motor. They immediately notified the maintenance bay supervisor who, in turn, directed the removal of Priority Level-1 resources from the immediate maintenance area. Just seconds after the last resource was transported from the area, the motor burst into flames. They then ensured all nonessential personnel evacuated the area and used fire extinguishers to contain the fire. The on-scene supervisor notified the fire department and munitions control personnel as TSgt Holmes, SSgt Farmer, and SSgt Kind controlled and eventu-

ally extinguished the fire. Fire department personnel arrived within minutes and determined that the fire was completely extinguished and allowed the return of all evacuated personnel. TSgt Holmes, SSgt Farmer, and SSgt Kind's keen attention to detail, along with their rapid response, averted potential personnel injury and damage to Priority Level-1 resources in excess of \$80M.



**TSgt Lamont Holmes, SSgt Jim B. Farmer  
SSgt Kevin L. Kind  
2nd Munitions Squadron  
2nd Bomb Wing  
Barksdale AFB, La.**



# MONTHLY AWARD WINNERS



**A**t sunset, approximately 8 hours into a contingency mission over hostile territory, the crew of CHARIOT 01 experienced battery failure. The flight engineer noticed a drop in voltage and a steady decay of battery power, indicating the battery was not being powered by the charger. The navigator plotted a course to directly exit the country while the crew began to conserve battery power. All non-essential aircraft battery-powered lighting and equipment was either turned off or disabled by pulling circuit breakers, which provided two additional volts to the dying system. Within 15 minutes, the navigator's panel lost power, and course guidance to the pilots' instruments and autopilot system failed. Over a country with erratic NAVAID reception, the aircraft commander maintained course manually using a backup portable GPS. The navigator verified position and course using charts, a second portable GPS, and moving map on a laptop computer. In the dark and using flashlights, the E-3B crew displayed exceptional composure and professionalism, and continued to execute their mission tactically while en route to their forward operating location, 2 hours away. Using a single console, the mission crew was able to provide traffic advisories and avoidance vectors to the aircraft commander and flight deck crew. As the crew exited the country and flew over the ocean, the mission radar had to be powered down. The navigator confirmed aircraft separation, posi-

tioning, and displacement from the coast for nearly an hour using the weather radar. Additionally, as the battery power slowly diminished, the crew lost engine fire detection and protection, engine ice and rain protection, and control of the fuel system cross-feed valves. The latter resulted in a 5,000-pound fuel imbalance. Left wing-heavy control pressures were neutralized with aileron trim. Ingenuity, superior airmanship and phenomenal crew coordination enabled the crew of CHARIOT 01 to safely land the aircraft 2 hours after the first indication of the problem.



<b>Capt Mark Williams</b>	<b>MSgt Timothy Beech</b>
<b>Capt Ismael Del Valle</b>	<b>SSgt Jason Graves</b>
<b>Capt Mihai Manta</b>	<b>SSgt Joy O'Boyle</b>
<b>MSgt Vernon Martin</b>	<b>SSgt Mark Rogers</b>
<b>Maj Michael Kirkman</b>	<b>SrA Matthew Coulter</b>
<b>Capt Craig Barrington</b>	<b>SrA Daniel Lee</b>
<b>Capt Joel Bourne</b>	<b>SrA Sarah Pena</b>
<b>Capt David Drass</b>	<b>SrA Andrew Ventitelli</b>
<b>Capt Panumat Shontz</b>	<b>SrA Roxanne Ziebarth</b>
	<b>A1C Michael Mast</b>

**963rd Airborne Air Control Squadron  
552nd Air Control Wing  
Tinker AFB, Okla.**



**A**ggressive safety program management led to an incredible safety record for this dynamic high OPSTEMPO unit. The program protected 161 troops working 34 projects within four countries and six locations in the USCENTAF AOR; that's over \$22M in projects vital to OEF/OIF operations. 1 ERHS troops forward deployed to Baghdad International Airport, Iraq, where they repaired an 8-foot deep, 100 foot diameter crater in the runway. Daily "Toolbox Safety Talks" and ORM processes were key in allowing them to safely finish the project restoring vital airlift capability to the Iraqi capital region in a mere 25 days. In addition, leadership dedication to ORM practices proved invaluable as 30 engineers worked through persistent rocket and mortar attacks, while

completing nearly \$4M of critical airfield and facility construction at Balad Air Base, Iraq. Additionally, a 106-person engineering team was simultaneously forward deployed to Bagram Air Base, Afghanistan. This team constructed a \$636K passenger terminal for OEF's hub, erected \$7.1M of Close Air Support facilities and maintenance shops for bed-down of an F-16 squadron, and constructed a new \$615K post office that processes 25K lbs of mail daily for all troops in Afghanistan. These focused efforts were personally recognized by the 455 AEW Chief of Safety for overall safety excellence and garnered the Camp Cunningham Superior Safety Performers Award for the month of May. During an in-garrison period, the crew palletized and shipped 1.5K tons of material to six sites with no serious injuries or equipment damage while also removing three bunkers, hauling 750 tons of sand, and 50 barriers and constructing 43 airlift containers for the passenger terminal. Overall, the 1 ERHS safely deployed 161 personnel and engaged in heavy construction ops throughout the AOR for 220 days with ZERO reportable mishaps.

**1st Expeditionary RED HORSE Squadron  
Al Udeid Air Base, Qatar**





**T**Sgt Cline, MSgt Hilton, and TSgt Sawyer displayed exceptional airmanship while handling a potential explosive situation at Bagram AB involving an A-10 loaded with one MK-82, one GBU-12, and high explosive 30 mm rounds that was parked in the middle of several other loaded A-10s. After the pilot initiated the engine start sequence on both engines, TSgt Cline (crew chief) began his launch procedures. All events were in accordance with tech data until 3 minutes into the process when TSgt Cline noticed an unusually high amount of smoke coming from the underside of the A-10 where the Auxiliary Power Unit (APU) exhaust emanates. MSgt Hilton (Production Superintendent) and TSgt Sawyer (Weapons Team Chief) also noticed the smoke. All three individuals immediately followed tech order procedures, unwound fire bottles, and began fighting the

smoke by inserting the nozzles into the APU exhaust port. The pilot quickly shut down both engines and evacuated. The trio acted selflessly and expediently. The fire department stated that, if the team had not acted immediately, major damage to the aircraft would have occurred. Their actions extinguished the possibility of fire in minimum time, preserved this aircraft, and ensured the integrity of the other combat-loaded aircraft on the squadron ramp.



**TSgt Elgin W. Cline, MSgt David R. Hilton  
TSgt Dana P. Sawyer  
455th Air Expeditionary Wing  
Beale AFB, Calif.**

## The Time is Now ...

**... To prepare for the upcoming Annual Safety Awards Season!** Although it's just September, the 1 November deadline is fast approaching and will be here before you know it, and you'll be left wondering where the time went and how can you get an extension. Well, you should know by now, there are no extensions! The AF Safety Center's (AFSC) suspense is 15 November -- that leaves exactly 9 workdays (commencing 1 Nov) to get the awards processed, through the awards board for selection, approved, and to AFSC for competition! So, my advice to you is to take the following tips and run with it:

- Deadline for all award nominations to ACC/SE is **1 November** (check with your NAF/DRU for their internal suspense)!
- Nominations *must* be submitted electronically using the latest version of the AF Form 1206 or the ACC-approved MS Word Document Format!

- Only one nomination per category is permitted unless noted otherwise!
- Winners at ACC will compete at the AF level for specific awards (See ACC/SE message or website for a complete list of award categories).
- Review all guidance (to include AFI 36-2833) for precise eligibility, selection criteria, format, etc.
- ACC/SE POC for awards is Barbara Taylor at [barbara.taylor@langley.af.mil](mailto:barbara.taylor@langley.af.mil) or DSN 574-8846.

Good Luck!



# MONTHLY AWARD WINNERS

## ACC Safety Salutes Superior Performance

### **Maj Douglas E. Morse**

High Altitude Reconnaissance Pilot  
5th Reconnaissance Squadron  
Osan AB, Korea

### **Capt Andrew A. Cardoza**

A-10 Fighter Pilot  
75th Fighter Squadron  
23rd Fighter Group  
Pope AFB, N.C.

### **Capt Joseph M. Biedenbach**

Squadron Flight Safety Officer  
79th Fighter Squadron  
20th Fighter Wing  
Shaw AFB, S.C.

### **Capt Nicholas J. Johnson**

F-16 Pilot  
27th Operations Group  
27th Fighter Wing  
Cannon AFB, N.M.

### **Amn Evan L. Harman**

366th Contracting Squadron  
366th Fighter Wing  
Mt Home AFB, Idaho

### **Mr. Mike Groce, DCC**

9th Aircraft Maint. Squadron  
9th Reconnaissance Wing  
Beale AFB, Calif.

### **Capt Brian Farmer, AC**

**Capt James Farm, CP**  
**1Lt Chad Fulkerson, OSO**  
**Capt Josh Nassef, DSO**

9th Bomb Squadron  
28th Bomb Squadron  
9th Expeditionary Bomb Squadron  
Diego Garcia

### **SSgt Christopher L. Zink**

**AC Maint. Spec. Transport**  
379th Expeditionary Aircraft Maint.  
Squadron  
Al Udeid AB, Qatar

### **TSgt Shannon J. Lambert**

Wing FOD Monitor  
9th Reconnaissance Wing  
Beale AFB, Calif.

### **SSgt Travis L. Surber**

Crew Chief  
379th Expeditionary Aircraft Maint. Squadron  
Al Udeid AB, Qatar

### **MSgt Carl J. Reichelt**

**SSgt Dennis Basch**  
**SSgt William Germany**  
**SSgt Christopher Hanks**  
**SSgt Heinz H. Mikat**  
**SrA Richard G. Hagan**  
**A1C Robert K. Brushel**

379th Expeditionary Aircraft Maint. Squadron  
Al Udeid AB, Qatar

### **SrA Jason P. Murphy**

Aerospace Ground Equip. Journeyman  
379th Expeditionary Aircraft Maint. Squadron  
Al Udeid AB, Qatar

### **Mr. Edgar Torres**

Security Forces Training Manager  
**SSgt Bradley Edwards**  
Vehicle NCO

379th Expeditionary Aircraft Maint. Squadron  
Al Udeid AB, Qatar

### **Maj Mike Randall, COS**

**SSgt Anuja Patel, GSM**  
12th Reconnaissance Squadron  
9th Reconnaissance Wing  
Beale AFB, Calif.

### **379th Expeditionary Security Forces Squadron**

Al Udeid AB, Qatar

### **455th Expeditionary Civil Engineer Squadron**

Deployed

### **Fuel Systems Hydrazine Response Team**

388th Component Maint. Squadron  
388th Fighter Wing  
Hill AFB, Utah

### **Crew 1**

**Lt Col George Elefterious, MCC**  
**Capt Royal Preston, SD**  
**Maj Joseph Braziel, DMCC**  
**Capt Nathan Andrews, SMO**  
**1Lt Charles Loiacono, AWO**  
**1Lt Jack Rhodes, AWO**  
**1Lt Mario Jimenez, AWO**  
**TSgt Ronnie Carter, SDT**  
**A1C Stephen VanPelt, AOT**  
**A1C John Manning, AOT**

### **Crew 2**



**Lt Col Drue McCroan, AC**  
**1Lt John Blackburn, CP**  
**Lt Col Thomas Wiswell, Nav**  
**TSgt Thad Allen, FE**  
**SSgt Alexis Adames, AIT**  
**SFC Glen Wright (USA), ATSS**  
**SSG Jeremy Welch (USA), ATSS**  
**TSgt Charlton Smith, CST**  
**A1C Steven Wiseniske, CST**  
**SrA Michael Bates, AMSS**  
128th Expeditionary Airborne Command  
& Control Squadron  
Deployed





# FY06 Aircraft

As of July 31, 2006









	Fatal	Aircraft Destroyed	Aircraft Damaged
8 AF			
9 AF			 **
12 AF			 
AWFC		 **  **	 **  **
ANG (ACC-gained)			
AFRC (ACC-gained)			



# Aircraft Notes

The Air Force had zero Class As this month -- a trend which would be great to continue. It doesn't mean that we are mishap free; there were Class Bs and Cs, but overall a great job! Force shaping will continue to affect our units, and if you haven't seen it yet, you will. Each of us must take ownership of the safety process to make the transition to the new force structure a smooth one. It is important that we, as flyers, know the regulations and procedures to ensure we are doing things the right way, the smart way, and the most efficient way. If not, then we need to work to change them! Fly Safe.

# FY06 Ground

As of July 31, 2006

	Fatal	Class A	Class B
8 AF		2	5
9 AF	    	7	3
12 AF	 	4	3
AWFC		1	2

 = Fatal  = Fatal due to misconduct

# FY06 Weapons

As of July 31, 2006

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

# Ground Notes

ACC has experienced four Class A fatalities so far in the 101 Critical Days of Summer. Three were the result of four-wheel PMV mishaps and one resulted from a two-wheel PMV mishap. Common casual factors include seat belts and speed.

# Weapons Notes

More good news for the weapons safety community. We continue our trend of reducing mishaps in all categories. We haven't had a reportable mishap since 7 Jun; GREAT WORK! However, we can always improve, and preventing AIM-9 sheared umbilicals from occurring is a good focus area for the upcoming month. Observe AIM-9 loading procedures and make sure they follow established guidance to the letter, and we won't see any more sheared umbilical mishaps. Again, thanks for all your efforts and continue to be vigilant.

## 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

