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The Combat Edge
Volume 17, Issue 3, ACC SP 914

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No Time to Relax

We are about to close out FY08 with a pretty good year of taking care of our people and watching out for our Wingmen. From October to July Air Force-wide:

- Overall ground fatalities were down 38%
- PMV fatalities were down 42%
- PMV4 fatalities down 57%
- PMV2 fatalities down 16%
- Sports and Recreation fatalities down 33%
- How did ACC compare for the same time period?

- Overall ground fatalities were down 57%
- PMV4 fatalities down 75%
- PMV2 fatalities down 20%
- Sports and Recreation fatalities down 66%

Overall Class A mishaps down 53%

The statistics look good but we need to remember they are numbers. We still lost some good friends and wingmen over the course of 10 months. This is no time to relax and get lulled to sleep by the improved statistics. We need to continue our great safety efforts to make FY09 even better. We have some recommendations and tools that can be useful in strengthening our safety culture.

AWARDS

We need to recognize the good work being done in the safety areas across ACC. ACC/SSE has a robust awards program that provides recognition from the MAJCOM level. That being said, we need your nominations. We have streamlined the nomination process to make it easier. Take the time to recognize the people that are working hard taking care of our people. https://afkm.wpafb.af.mil/ASPs/CoP/OpenCoP.asp?Filter=00-SE-AC-23

COMBAT EDGE ARTICLES

Spread the word! There are a lot of great stories, perspectives and most importantly Lessons Learned to be shared. Encourage your folks to spend a few minutes and write down and submit their thoughts and experiences.

COMMANDERS/SUPERVISORS TOOL BOX

We have been working with the Safety Center to provide one stop shopping for Safety information and associated safety tools for commanders and supervisors. Included in the toolbox are briefing guides, targeted mishap prevention information and a link to the Air Force Culture Assessment Safety Tool (AFCAST). AFCAST is a web-enabled 10-15 minute survey designed for the Squadron Commander to measure the safety climate within their organization. We will continue to populate the site with updated information. http://afsafety.af.mil

We are here to help you, let us know what we can do to make your Safety environment better. Again I thank you all for the great work!! Keep it up, now is not the time to relax.
Fighter pilots, specifically single-seat pilots, face some of the most challenging flight environments. We have to organize our own resources plus work as a team to accomplish the mission while preparing for such immediate contingencies as weather, threats, in-flight emergencies (IFEs), and alternate missions … to name a few. Most of the time, these unexpected and unanticipated contingencies can only be overcome by skill, experience and/or training. If not overcome by skill and training, the situation can deteriorate into a helmet fire. These “helmet fires” (otherwise known as task saturation, mis-prioritization, situational awareness (SA), and channelized attention) can get the best of us, resulting in mishaps. As a matter of fact, task mis-prioritization, situational awareness, and risk assessment/decision making are the three most frequently cited causes of ops-related USAF fighter mishaps.

Despite proactive programs and efforts in the fighter community, we continue to struggle to eliminate our Class A mishap rates. The study of human factors in aviation has evolved and grown in the pursuit of understanding the “fighter pilot.” But one constant remains – flight mishaps due to human factors! Basically, the pilot just screwed up or let his guard down. Modern day mishap statistics indicate 70 to 80 percent of aviation mishaps center on human factors (HF). Throughout aviation history, nothing has changed regardless of our futile attempts to reduce human factors related aviation mishaps. A 1943 Pilot Information File states: “Pilot Error is the cause of 70 to 80 percent of all aircraft accidents.” Solomon was right when he wrote in Ecclesiastes, “What has been will be again; what has been done will be done again; there is nothing new under the sun.”

Skill-Based Errors (inadvertent ops, checklist errors, procedural errors, over/under control, inadequate Anti-G Staining Maneuver … to name a few) overwhelmingly comprise the greatest number of pilot errors as the root cause of most fighter mishaps. Most safety programs don’t address how to fix Skill-Based Errors. The bottom line is YOU have to fix the problem because YOU are, most likely, the problem, not the safety system.

Putting out “helmet fires” involves staying ahead of the jet through “preparation” and “anticipation” – preparing for the “worst case” and anticipating the next event in the chain. Techniques on how to manage “helmet fires” vary, but here are some proven concepts that have helped me survive almost 3,000 hours in fighters. Maybe these concepts and techniques will help YOU get your act together and help us reduce the Skilled-Based Errors that are destroying our fighter force.
You should have a personal fitness program, including proper nutrition (a balance of carbs, protein, and good fats), and you should be getting enough pilot rest to maintain a high degree of alertness and beat fatigue. If not, make some lifestyle changes. Increase strength, endurance and cockpit mobility by getting in shape with a combination of cardio and weight training.

**PREPARATION**

Mission planning – led by the flight lead, the flight should plan together as a team. The mission will flow smoothly even if you’re faced with contingencies or problems. Focused and focused tactics have a higher chance of success than complex plans with little margin for error or room for contingencies. Flights should be planned to minimize the workload through the use of user friendly, organized products such as an organized line-up card with color, a comm-card with frequencies listed in sequential order, and a map with good detail and easy to read information. The way a pilot folds a map prior to the flight could create a confusion or give the pilot more time to think and react to other situations.

You’re then climbing an uphill battle in an attempt to re-gain awareness. When you’re ahead of the jet, you can project and ask the “What If?” questions. Wingman anticipation – anticipate and lead turn the next page during low altitude and high G tasks.

**ANTICIPATION**

Anticipation is forecasting using your best judgment; a by-product of experience. It’s thinking ahead … gathering information and making mental clarification and vali- dations … scanning instruments, systems, your Wingmen and flight lead to keep SA high in order to anticipate the next event.

When you’re behind the jet, you’re not anticipating. You’re then climbing an uphill battle in an attempt to re-gain awareness. When you’re ahead of the jet, you can project and ask the “What If?” questions.
The above incident, at a minimum, is a Class C mishap. This is due to the loss of duty time of the individual. What if your shortcut caused the loss of life or an aircraft? How about if it resulted in an explosives mishap? Was it worth it? Are your career and people’s lives worth it? These are the questions that we have to continually ask ourselves.

I firmly believe that integrity and safety go hand in hand. We have to do what is right even when nobody is looking. It needs to start with the most junior among us and go right to the top. We, as the frontline supervisors, have to put a stop to the shortcuts we see happening in the bomb dumps, flight lines and maintenance facilities. The warnings, cautions and notes in our technical data, along with regulations and supplements all stem from the knowledge of subject matter experts and those of us who have had unfortunate incidents. The guidance is there for a reason … for us to follow it as written so we do not have repeat incidents.

Unfortunately, some of us have to have an eye opening experience before we realize the seriousness of our jobs and the consequences that can happen. I was lucky enough to have that experience on my first day at my first duty station. I was at lodging waiting for my sponsor to take me out to the bomb dump to meet my new coworkers. As we were driving, we passed our entire shop, shouting and waiving for us to pull over. After my sponsor had left the shop to pick me up, an ALA-17/B flare started smoking as the flare crew was conducting an electrical test. The crew chief followed his checklist and made the proper notifications, leading to an evacuation of the bomb dump and the calling of Explosives Ordnance Disposal (EOD). Luckily, the flare did not ignite and EOD was able to handle the incident with little to no problem. I learned at that moment that this was a serious job, and that my understanding and ability to follow technical data would be imperative throughout my career.

We tell our stories for a reason: so that those without our experience can learn and understand. We all make mistakes, but most are preventable. We just need to slow down, take a step back, and follow the guidance that is in place … even when nobody is looking!
Halloween Safety
by MSgt Judi Butler, Eglin AFB, Fla.

The leaves are beautiful hues of amber and crimson. The nights are chilly and the smell of fall is in the air. Children have been planning for this night since July only to change their costume ideas a hundred times. As they run around the house with their fairy wings and pirate swords, several things come to mind. Will her wings get caught on a tree branch, can he fall down and jab himself with his sword? There are several things to think about before the annual parade of ghouls and goblins.

First and foremost, costume safety is of the utmost importance. Remember to make sure eye and mouth holes are large enough on their masks to allow for proper ventilation and peripheral vision. If your little grim reaper is carrying a scythe or pitchfork, it needs to be made of soft, smooth plastic or rubber and flexible in case of a fall. Make sure your princess is wearing comfortable shoes, not 4-inch high stilettos. Nothing ruins a night of trick or treating worse than feet full of blisters.

The pumpkin has been carved by an adult and ready for the porch or step. We need to bring this Jack-O-Lantern to life. Candles create an eerie but warm glow; however, nowadays we are blessed with battery-operated pumpkin lights. You can find them at any store or pharmacy that specializes in seasonal items. It’s a safe alternative to using fire. If you do choose the traditional candlelit pumpkin, ensure your candle is short enough to avoid burning the pumpkin lid.

Place the Jack-O-Lantern away from foot traffic so you don’t light a ghost or princess on fire. That would ruin the night real fast.

At last, dusk has arrived and the kids are dressed in safe, comfortable costumes. They are excited to get out there and gather their goodies. To avoid your children from eating half of their saved treasure on the goblin parade, make a warm, hearty dinner. Also, you might want to set a rule before you venture out: Do not eat any candy until an adult has checked it out first.

As a safety minded parent, you know you need to arm your children with flashlights, reflective tape and a sturdy sack or bucket for candy. Remember, safety in numbers; it’s not only fun but safer to travel in groups. Remember to bring at least one adult per group. While traveling from house to house, stay on the sidewalk and hopefully you’ve chosen a route lined with streetlights. Don’t forget, cross-walks are there to protect the pedestrian ... use them!

Finally, you’ve left the last house on the route and you’re ready to head home and investigate their treasure. Everyone races home to dump the candy on the kitchen table. The children are already bartering a super sour ball for a chocolate candy bar. Make sure you check each piece of candy closely. Throw out all opened, punctured or unwrapped candy. Even better, have the candy X-rayed. Check your local Emergency Room; some may X-ray Halloween candy for free. Make Halloween a fun and safe time for your kids. You have started them on the right path for years to come.
Spot inspections can be a great tool for the overall success of a weapons safety program; they are conducted on some aspect of our program every single day. These spot inspections may include, but are not limited to: a facility fire symbol check with the Fire Alarm Control Center, or quick glance at an Additional Duty Weapons Safety Representative's training documentation, or a complete upload operation on the flight line. The keys to this program are understanding, proper documentation, following up, utilizing the data, and passing the word.

When I first started at the Weapons Safety office in January of this year, one of the first policy letters I reviewed was from the Chief of Safety. It broke down the quantity of required spot inspections from each safety discipline per month. Being fresh out of the munitions storage area and new to the weapons safety world, my only knowledge of this kind of quota was from my dealings with QA. After some time in the field conducting my own spot inspections, I realized my previous knowledge was inaccurate and that I didn’t actually know what a properly documented safety spot inspection was or what the real purpose was behind them.

According to AFI 91-202, spot inspections are notice to check the day-to-day safety and health of an organization, work center, facility, etc. After giving this some careful thought, I deduced that the purpose of a spot inspection is not to grab your clipboard and go out looking to meet a write-up quota, but more so to offer assistance to strengthen the safety program itself. One day at “Base X,” I found myself on the flight line observing a load crew preparing for an upload of Mk 84s. While my partner and I waited for the operation to begin, I noticed the Line Delivery crew pull up towing the munitions to be loaded. They parted; so I decided to go do a quick spot inspection on them while we waited for the load crew to get started. As I approached the bobtail, I immediately recognized the crew chief as a Staff Sergeant who had worked for me on a recent deployment, prior to my appointment to Weapons Safety. I could almost predict what was, or wasn’t, going to happen next. I knocked on the window, he rolled it down and greeted me with the usual “What’s up boss?!” I replied to his greeting and introduced myself as Weapons Safety. I stood there waiting to hear a crew briefing that just wasn’t coming. After an awkward pause and stare from him, I finally asked for the briefing. I could tell he was kind of beside himself for knowing better. I noted this as a finding during my spot inspection and briefed the section chief later that day. Was it something that got the crew chief fired or decertified? Was this my intent? Of course not! However, it is something I should be concerned with if I enter more operations and not get the required crew briefing.

The only way to track this is through proper documentation. AFI 91-202 states: “Minimum documentation will include date, inspector’s name, organization or activity inspected, unit point of contact, and a brief description of what was observed, if there was/was not a discrepancy and of the status (open/closed).” This statement is pretty cut and dry; if you document all of the details listed, there won’t be anything left to question when you are reviewing later. That sums up proper documentation, but there is still more to this process.

Following up may be one of the most overlooked steps. We must go back to make sure our recommended fixes are working. This is the only way to know if the recommended actions solve the problem. Many of us use a database program to help track our spot inspections and many have a feature that allows us to review any open spot-inspection findings. This is a great and handy tool, but it is also an easy one to forget to use (personal experience).

So far we’ve briefly covered documentation and following up; one other important aspect of the spot-inspection process is to get the word out to others on the base that have the potential to experience the same occurrence and may benefit from the information. There are a couple of very effective ways to do this. One is a weapons safety newsletter and another is a meeting with your Additional Duty Weapons Safety Managers. You can complete either of these monthly or quarterly; the quantity and urgency of the information will dictate the frequency. Neither has to be a masterpiece, as long as the information is pertinent and useful.

Lastly, we utilize the results of our spot inspections in a variety of different ways. One of the required applications of this data is trend analysis. According to AFI 91-202, ACC SUP1, we are to conduct a semiannual trend analysis of applicable safety inspections, mishaps, deficiencies, and hazard reports to identify problem areas. Reviewing spot inspections from the past can easily identify areas that have repeat occurrences. When conducting spot inspections, the one thing to keep in mind is the larger the amount of data collected (i.e., more spot inspections) the more obvious the trends will be to identify. Trends aren’t always negative! Make sure to identify positive trends as well. They can go a long way for getting recognition for your folks.

The bottom line is that we can inspect different areas and note what we see, but if we do not properly document our findings, conduct follow-up actions, utilize our results, and pass the findings along to folks who can benefit and learn from them, we are wasting one of the most powerful tools we have.
My Brother’s Keeper

by Lt Col Eric Denny, Nellis AFB, Nev.

What does being a good Wingman really mean? As a fighter pilot, the Wingman concept is part of the mission. Here’s how I think about it. When out on a training or real world mission, I rely on my Wingman for support and mutual defense. From my point of view, my Wingman has two roles to play that are based on the nature of the situation. If we are in an administrative phase of flight, I expect him to offer suggestive inputs. For example, say I am trying to find the tanker in the air refueling orbit and happen to bite off on the wrong aircraft. If he has situational awareness that the correct aircraft is off our wing instead of off the nose, he might suggest “Viper One, confirm the tanker we’re looking for is right 3 o’clock, not off the nose.” The point is this; he communicates that I am messing up and gets us back on task and does so in a manner that won’t cause me to read him the riot act for overstepping his bounds — appropriate for the situation since it is not life threatening. On the other hand, if we are executing a critical portion of the flight, say engaging the enemy in air combat, I expect my Wingman to act in a much more directive manner if he has the awareness that will save our lives and kill the enemy. For example, he looks over his shoulder and sees an enemy aircraft rolling in on our six o’clock position about to shoot a missile. In this case, I expect him to take command of the situation and direct actions. “Viper one, break right, flare now, hostile your six o’clock one mile.” When the situation is critical and we may die, I expect my Wingman to take positive actions to ensure our survival.

As a military member, whether you fly fighters, walk the line, or shape metal in the back shop the Wingman concept applies. It is really just an Air Force adaptation of the age old principle of teamwork. Very little can be accomplished effectively in the military without teamwork. We are dependant on each other to get the mission done. As Wingmen, sometimes we make suggestive inputs, and sometimes when the situation is critical, we make directive inputs to ensure we accomplish the mission and get home alive.

Yeah I know, so what’s the point? The point is this; the Wingman concept is directly transferable to off-duty situations as well. What’s more we have a responsibility to our friends and family to apply it just as we would on duty. Let me give you two examples of what I mean. Say you and a friend are going out to ride ATVs at a new trail you just read about in the paper. When you get there, your bud jumps on his ATV and is about to blaze off without any knowledge of the trail or local conditions. Before he does, you suggest looking at the posted trail map and familiarizing yourselves with the trail and possible hazards before taking off. Sure enough, there is a switchback somewhere and now you are both armed with the knowledge you need to slow down at mile 4 to prevent plummeting off the edge of a cliff. Now how about this one? You invite a buddy over to party at 11 pm on a Saturday night. Nothing too crazy, but he has some drinks early on. Around sunrise, your buddy, who has been hanging out with you all night, decides it’s time to go home. You are pretty sure he is okay, alcohol wise, because he hasn’t drank for a few hours, but he has been up all night. As a friend, you offer up the couch and suggest a couple hours sleep before trying to drive. He declines.

Here’s the point. Is this an administrative situation or a critical situation? I would argue that this is a critical situation and it is time to be directive rather than suggestive. Don’t give in to his refusal to sleep before driving. Take his keys and demand he get a few hours rest before he takes off. I know what you are thinking… that is way too pushy. Well consider this before you make up your mind; your buddy takes off for his 20-minute drive, falls asleep at the wheel, the car goes out of control, crashes and he’s dead. Don’t forget, YOU invited him to the party, YOU watched him drink alcohol and YOU stayed up with him all night. You basically participated in forging all the links in the mishap chain and helped create the critical situation that notionally resulted in your buddy’s death. Fatigue and alcohol are reoccurring factors in traffic accident injuries and deaths. Don’t drink anything if you are going to drive and don’t allow your friends to either. If you see your buddy in a situation (regardless of whether you helped him get there) that includes alcohol, fatigue, and driving, recognize that it is a critical one. Act positively to prevent the dangerous behavior. After all, a few minutes of arguing are a lot less stressful than consoling a grieving family at the funeral. Check six.
When my ordeal started, the pain in my feet was comparable to what anyone might experience with a minor bruise. It was barely an ache. It was more like what happens on Saint Patty’s Day when you forget to wear green — a sharp, unexpected pain that makes you jump and say “Ouch!” and then is over. It was not exactly laughable, but there were no physical signs of damage.

Then a few days passed and I found myself using the side crescent of my feet to gradually stand and stretch. The pain then was best described by words like “throb,” “sting” and “fire.” By Tuesday, I was the last one to finish the PT run. By Thursday, I barely made it through calisthenics that used to be a breeze. By Friday, all I could do was sit on a bike and pedal slowly. I should have seen red flags all over the place, but I had my pride and it, unfortunately, kept me going for another 4 months.

It didn’t seem to matter to that pride that my runs became slow and embarrassing. Forget high knees, I could see people with my peripheral eagle eyes who must have been thinking I was running in place on purpose! My humiliation increased with the number of butt-in-air pushups I was performing due to an escalating lack of mobility.

The word “throb” changed to “hip hop concert bass pounding.” “Sting” became “volcanic eruptions chas- ing screaming townfolk.” The more appropriate pain descriptions quickly became words like “violent,” “searing” and “thrashing,” as in what a pro-wrestler does to his opponent. All of which dissolved whatever pride remained and I, finally, made an appointment to see a doctor.

That’s when I found out that I had waited much too long. The diagnosis: both “Plantar Fasciitis” and potential shin splints also known as (a.k.a.) medial tibial stress syndrome a.k.a. stress-related anterior lower leg pain a.k.a. the reason for all the scorching shin agony after jogging for only 5 minutes. This kind of pain doesn’t simply exist; it attacks with a magnitude that’s off the Richter scale.

If you haven’t heard, “Plantar Fasciitis” is an inflammation of the connective tissue covering the sole of the foot. The location is simple. Place your index finger on your heel bone also known as the calcaneus. Move it towards your big toe or metatarsus and stop when you get to where the arch of your foot and your heel meet. Press hard; that’s your “Plantar Fascia.”

When it is constantly aggravated, it gets inFLAMEd, which describes the intense burning sensation that occurs. You can mimic the process by making a fist with your hand and squeezing it as hard as you can for 1 minute and then releasing. This is how the tissue gets sore and battered from all-day usage. When you rest, the swollen tissue contracts. When you get up to walk, you are stretching that same swollen tissue back out. You could describe this by using the words “tear” and “flesh” together. Most activity will cause this condition to become worse if not treated.

What does all this mean? It means I now have to wear annoying rubber cups in my boots. I have to take Naproxen until that stops working. At which point, my feet get injected with a potion that is only 50 percent effective. If all else fails, I am facing the real possibility of surgery.

The sad reality is that I’m not alone. This condition is common, if not THE MOST common, running condition that affects Air Force members. In my case, it was all spawned by lack of information, lack of worry, and an increasing fear of failure, aggravated by a poor attitude, anger and the horizontally spreading nature of my gut.

My advice is, if anything I’ve described sounds familiar, make an appointment with a doctor. Make it for yourself, for a coworker, for a subordinate, or for a family member. It doesn’t matter what the relationship, just make the appointment. Don’t become a hobbling cliché advertisement for the “I wish I had caught it sooner” crowd. The ramifications go far beyond a PT test failure or a potentially bad EPR; your ability to walk is at stake and that affects the mission and your future.
Locked in a Car
by 2Lt Dana R. Thomas, Peterson AFB, Colo.

It’s 1300 in the afternoon, and Lieutenant Thomas is leaving the Peterson AFB medical clinic after taking his 3-year-old son to a Pediatrics appointment. It’s a beautiful sunny day in Colorado Springs. As he pauses to readjust the ties on his son’s shoes, he’s startled by the sounding alarm of a pickup truck as it bleats out a warning from a nearby parking space. Curious as to what caused the disruption, Lt Thomas approaches the vehicle and peers into the darkened vehicle in time to see a small girl climbing from an enclosed vehicle on a warm day.

At the same time, the sound of nervous laughter is observed by Thomas as he notices two more small children in the rear seat of the locked vehicle. Shocked at this discovery, Thomas steps up to the slightly “cracked” open window and asks the children inside, “Are you kids all right in there?” One of the children answers, “I’m thirsty!” quickly followed by another small voice stating, “I have to go potty!” Thomas ponders his next move, as he knows from previous experiences that it is illegal to leave such small children unattended on a military installation and in several states. Also, he considers the danger that an enclosed vehicle poses to these small children in the high frontier summer sun.

Thomas tells the children to stay put, and then takes his son Nicholas back inside the clinic to secure some assistance from the staff. After enlisting the help of a couple of volunteers, Thomas returns and lets his son play in the shade while holding watch over the vehicle until the security police arrive to take charge of the situation. After a short time, the SFS personnel arrive, and as Lt Thomas collects his 3-year-old son, a confused and upset mother exits the clinic west doors to be greeted by law enforcement personnel. Satisfied the situation will be resolved appropriately, Thomas and his son leave the area with a feeling of relief knowing that a bad situation and a possibly tragic outcome have been prevented from worsening.

Although this situation would seem to be a no-brainer, it happens far too often in America. Each year several children, most of which are too small to be able to defend themselves from the hostile environment of an enclosed automobile, are tragically lost to the careless event described above. According to a recent article published in the Journal of the American Academy of Pediatrics, between 1998 and 2002, an average of 29 children were killed annually from being left inside an enclosed (or partially enclosed) vehicle on a warm day.

Unfortunately, this news isn’t really new, as evidenced by recent stories aired on the major television news networks and high-profile stories of tragedy over the last few years. An online article by researchers from San Francisco State University further undermines the problem as the number of annual deaths continues to rise each year despite increased publicity given to the issue. In fact, the average of 29 deaths per year as stated above rose almost 31 percent to 42 child deaths in the year 2005.

Some parents may think that leaving the windows partially open or “cracked” will prevent heat injuries to children left in a parked vehicle. Studies have shown partially opened windows initially slow the rate of temperature increase inside a parked vehicle for the first 30 minutes. However, when the temperatures measured inside the test vehicle were tracked for 60 minutes, there was little difference on the final temperatures that the internal environment of a parked car achieved.

In fact, all of the test vehicles averaged a temperature rise of 41-degrees Fahrenheit after left parked during mid-afternoon daylight conditions for 1 hour. This was during ambient temperatures ranging from 73 to 93 degrees. Even on the moderate temperatures of a 73-degree day, the internal temperature of the test automobiles rose to around 117 degrees within 60 minutes, with 80 percent of that temperature rise occurring during the first 30 minutes.

Younger children run the highest risk of injury, as evidenced by statistics stating almost 60 percent of fatalities related to children left unattended in parked vehicles were in children less than 12 months of age. Although not covered in this source, other research reviewed in preparation of this article led the researcher to believe that infant children have particular difficulty regulating their body temperature in the hostile environment of a hot vehicle. Leaving a child in an unattended enclosed car can lead to senseless tragedy. Children left in a vehicle have the possibility of being exposed to an environment that is very hostile to their small bodies and places them at a huge risk of sustaining heat injury or suffering heat-related death. Parents must be especially aware of this danger to their children, and make sure to never leave their children unattended in a parked vehicle. The risk just isn’t worth the little amount of time saved by not taking them along.

Also, a disturbing factor noted during the research for this article was that approximately one-fifth of these heat injuries or fatalities occurred while the children were in the custody of a daycare provider. Parents must be especially vigilant in the choosing and monitoring of daycare providers to ensure that their children are not exposed to this type of risk! Keep them cool – don’t let your kids be victims of heat-related injuries!"
I have been working in the Safety job for a little over 4 months. During my career, I have been a witness to several safety incidents or violations that were attributed to what I believe the largest problem we face in our working environment today. This problem would be the lack of respect which in turn causes careless behavior with the weapons and machines we work with every day.

In one incident, two Airmen backed the vehicle they were driving into another vehicle. This occurred because they decided to implement a shortcut instead of following procedure. The passenger should have gotten out of the vehicle to “spot” the driver, but the decision was made by both individuals that this was not a necessary step. Instead of following a procedure that would have taken 2 extra minutes to complete, they decided to act carelessly and do things their way. The shortcut ended up costing the Air Force around $1,500 to repair and several man-hours for reporting and repairing these damages.

Another example of this problem was when several Airmen riding the transport bus back to their shop for shift change were joking around with each other. The joking around was taken too far when one of the Airmen made a joke regarding an acquaintance of his coworker. This joke insulted his coworker, and after being insulted, the coworker, in jest, chambered a round into his M-4 rifle. The others on the bus emphatically told him to remove the clip, but when he attempted to remove the clip, it was stuck. He made the decision to wait until he could get to the cleaning barrel back at his shop in order to clear the weapon. In the meantime, he rested the loaded weapon against his side, and while he was waiting to arrive at his shop, the gun fired. This unintentional firing shot an innocent bystander in the foot. Due to the lack of respect, careless behavior, and the total disregard of weapon safety that was represented by this Airman, an innocent bystander was injured and received 10 days of quarters.

In a final example, an explosives team was to perform a demonstration for three visitors at their demolition range. Instead of taking out the authorized amount of explosives, the decision was made to take out more than twice the authorized amount. This team then allowed visitors to handle the explosives prior to giving the required explosives safety training and test. The visitors were allowed to watch the detonation from within the authorized distance, “safe area,” for personnel but not the authorized distance for visitors. One of the explosives was set outside of the authorized demolition area, and when it was detonated, fragments and firebrands from this detonation landed in a grassy area causing a wild fire to occur. The base fire department was notified which, in turn, deployed 12 trucks and 40 personnel in order to fight the fire. Since the wind continued to increase in speed, the fire spread beyond the base boundary so several local fire departments had to respond. This fire not only destroyed over 2,000 acres of grassland, several sections of fencing, and one barn, but it cost approximately $100,500 in estimated damages. All of this resulted because the mandated safety rules that are put into place for the safety of all were ignored. In other words, carelessness resulted in this incident.

In all three of the abovementioned instances, a complete lack of respect for safety rules, along with careless behavior resulted in situations that could have been averted. Procedural guidelines and safety rules have been established in order to protect not only military personnel and property but also civilians and non-military property from becoming harmed or destroyed. With the incidents that were mentioned and those left untold, we are left with several questions that will continue to be debated. Most importantly, the lack of respect and lackadaisical attitude towards the rules are the result of poor training or our supervisors that are too young and inexperienced to understand and appreciate the effects that will occur if the rules are not followed.
**AWARD OF DISTINCTION**

**Flight Line Safety**

Maj Christopher L. LaJeunesse
9th Reconnaissance Wing
Beale AFB, Calif.

Once he reduced his gross weight to an acceptable level, he flew a textbook approach to the airfield. Maj LaJeunesse skillfully landed in the first 1,000 feet of runway, allowing the maximum distance remaining to utilize the emergency braking system. He brought the aircraft to a stop on the runway and egressed the aircraft, with the assistance of the emergency responders. Maj LaJeunesse’s superior flying skills preserved a National Command Authority high altitude intelligence, surveillance and reconnaissance asset.

**Ground Safety**

Sgt Glaub was responsible for the first “407 ECES Safety Day” held. His efforts culminated in a day focused on safety, team building, and esprit de corps. The day consisted of a Group Safety sponsored FOD walk, where 407 ECES conducted a sweep of the southern quadrant of the airfield, safety-focused obstacle course, live-fire extinguisher training, and Commander’s Call. He took the lead to design an obstacle course that was reflective of the unique risks and mitigating actions associated with the various specialties assigned to the Civil Engineer Squadron, and was in accordance with guidelines set by the Commander that each obstacle pose no risk of injury and required at least one PPE item routinely worn by each section. He placed each obstacle in a logical order so that the course smoothly transitioned from one obstacle to the next. Each three-person team faced a spectrum of tasks that included palingizng boxes, knocking over cones with water from a fire hose, assembling a plywood jigsaw puzzle wearing welding gloves, UXO identification, using a transit to read a math problem and solve, installing ECU electrical cords and duct work, reducing utility pipes from 63mm to 1 inch, and moving a wheel barrel filled with sandbags through a series of cones. Sgt Glaub arranged fire extinguisher training, to include classroom lecture and the opportunity to don PPE and extinguish a controlled fire. In all, this was another strong link in the chain that has resulted in the safest, most accident-free, and recognized 407 ECES rotations ever.

**Pilot Safety**

Major Chris “Juice” LaJeunesse departed Beale AFB on a 5-hour high-altitude FTU training flight in the U-2S. After an uneventful heavyweight takeoff and passing 5,000 feet, he detected an unresponsive pitch trim system. Maj LaJeunesse scanned his instruments and noticed the hydraulic pressure gauge rapidly decreasing to 0 psi, which triggered multiple system alarms. He analyzed the problem as either a failure of the aircraft’s sole hydraulic pump or a massive fluid leak. He arrested his climb and turned back toward the airfield. Maj LaJeunesse’s aircraft was left without landing gear control, speed brakes, wing flaps and pitch trim. After establishing contact with the Beale Supervisor of Flying and the Chase Car officer, he declared an emergency and began adjusting gross weight to allow for a safe landing. Once he reduced his gross weight to an acceptable level, he flew a textbook approach to the airfield. Maj LaJeunesse skillfully landed in the first 1,000 feet of runway, allowing the maximum distance remaining to utilize the emergency braking system. He brought the aircraft to a stop on the runway and egressed the aircraft, with the assistance of the emergency responders. Maj LaJeunesse’s superior flying skills preserved a National Command Authority high altitude intelligence, surveillance and reconnaissance asset.

**Weapons Safety**

Sgt McLenahan used his unparalleled knowledge to identify a contractor’s safety discrepancy with storage and handling of dynamite for a base air show. While preparing for the air show, he arranged a detailed compatibility waiver for jet-assisted take-off bottles for the USN’s Blue Angels demonstration team. His Munitions Control section went defect-free and received laudatory comments from the inspection team. Sgt McLenahan is the one leadership turns to. With no notice, a C-17 diverted to Barksdale AFB for a higher priority mission and Sgt McLenahan quickly facilitated safe beddown and follow-on ground movement of USA Patriot missiles. He also engineered expedient transfer of facilities, and initiated CE response for downed power lines. He led a project, with system engineers, to re-structure the Wide Area Local Area Network in the Munitions Storage Area, ensuring they understood mission requirements and provided them with safe electro-magnetic distances. His expertise has been instrumental in rejuvenating a capability that has never worked properly. Sgt McLenahan exemplifies the cardinal rules of weapons safety, while protecting ACC’s largest explosives stockpile.

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Crew Chief Safety

As part of the initial turnover process, the 557 ERHS Operations Flight conducted a facility Safety Assessment of their K-Span, building #5237, finding significant life, safety, and health concerns. An unfinished staircase within the building was being utilized to gain access to a second floor locker storage area. Supervision immediately barricaded the staircase then promptly added handrails, thus eliminating the hazard to personnel utilizing the staircase. While testing the building’s central fire detection prevention system, they realized the system was not operating properly. The K-Span building is the 557 ERHS central hub for all projects located on LSA Anaconda/Balad AB, Iraq. Supervision utilized their in-house utilities and electrical craftman to troubleshoot and pinpoint the cause of the malfunctioned fire detection panel. With their expertise they were able to rewrite the system making the fire detection panel fully operational. They also labeled and organized all wire connections to ease any future troubleshooting with the fire panel; however, the job was not complete. Next supervision contacted 332 EAW Fire Prevention asking for an operational check to ensure the K-Span fire panel was in compliance and operational. The fire department responded, conducted an operational function check of the system, and advised the panel was fully operational. They went to great lengths ensuring the preservation of hundreds of thousands of dollars in materials and equipment, more importantly assuring quick response in the event the fire department is needed preventing possible injuries or loss of life.

Aircrew Safety

During a combat support mission in support of Operation ENDURING FREEDOM, an RQ-4 experienced multiple system malfunctions. Analysis revealed the aircraft was experiencing a failure of the Environmental Control System (ECS), placing the aircraft at risk of freezing the central on-board computer and fuel systems. The aircraft experienced nine total ECS faults resulting from abnormally low atmospheric temperatures. The crew terminated the mission and initiated a return to home station. The sensor operator displayed exceptional airmanship by assisting the pilot on all 13 fault indications relating to the emergency. All aircraft temperature data was reported to the Global Hawk Operations Center (GHOC), tracking trend information, and enabling the operations supervisor to accurately access the situation. En route to the recovery base, the crew descended to warmer air after receiving two more faults indicating imminent threat to the aircraft, requiring the crew and GHOC pilot to coordinate altitude and traffic avoidance with multiple controllers and support agencies. When the pilot had difficulty communicating with foreign ATC controllers over the radio, the controlling agency denied clearance to enter the destination country. The GHOC pilot called foreign ATC controllers to communicate the crew’s intentions and get clearance to continue inbound. The on-board imagery sensor, which provides heat to the aircraft, malfunctioned. This crew’s ability to function as a cohesive team under pressure proved invaluable to the recovery of a national reconnaissance asset.

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**MONTHLY AWARD WINNERS – JULY**

**Aircrew Safety**

**AWARD OF DISTINCTION**

During the cruise portion of a 20+ hour KOA LIGHTNING HHD sortie, HAVOC 08 suddenly experienced large aircraft pitch oscillations with a magnitude that exceeded the load factor limitations of the aircraft. The violent pitch oscillations caused the crew to be thrown to the limits of their restraints, and struck by loose equipment that had been displaced by the negative Gs experienced. The AC and CP attempted to regain aircraft control by performing the “Unscheduled Autopilot Inputs” boldface. However, the aircraft continued its extreme maneuvers. The IP then directed the AC to disengage the Pitch SAS and pull the respective circuit breakers to ensure no faulty pitch signals would be sent to the flight controls. After disengaging the Pitch SAS, the severe pitch oscillations terminated, and the AC regained control of the aircraft and corrected the 1,000’ altitude deviation. They terminated the mission, declared an emergency with ATC, and coordinated the return to the remote island FOL with the “over Gd” aircraft. After returning to the FOL, the crew held a debrief to burn down fuel during a period of degraded weather and congested airspace. With ATC described “extreme rain showers” approaching the island, the crew expedited the burn rate and obtained OG/CC authorization to land the emergency aircraft before the adverse weather struck the airfield. The pilots executed a textbook controllability check approach and landing. The crew mitigated the risk to aircraft and crew while following all associated directives/T.O. procedures.

**Pilot Safety**

**AWARD OF DISTINCTION**

While TDY to Langley AFB in support of continuation training for the 1 FW, Maj Miller had actuated the auto pilot multiple times in this airplane without incident. During the take-off roll, while traveling at approximately 80 knots, Major Miller’s flight crew and communications technicians noticed very strong, pungent odors in the aircraft cabin. The crew noted the aircraft’s comm system was becoming very “scratchy,” as if the entire internal communication system was fading. As the aircraft reached 120 knots on take-off roll, both the internal and external communications systems failed completely. Realizing that the crew faced an ambiguous compound emergency with total loss of comm, Maj Miller called “reject,” executed his boldface, and completed a high-speed abort of the takeoff. Once stopped, Maj Miller directed the flight engineer to calculate the aircraft brake energy, which indicated within “Caution” parameters, but nearing the “Danger” range. The flight crew donned their oxygen masks and awaited further orders. The crew did not have the ability to initiate, nor safely complete, the “Fire, Smoke, and Fumes in Aircraft Interior” checklist and were unable to notify tower for emergency response services. Confronted with very strong fumes in the aircraft, and no way to safely complete the checklist to identify the source of the fumes, Maj Miller directed the crew to egress the aircraft. All personnel exited the aircraft using the escape slides, despite one slide failing completely.

**Unit Safety**

**AWARD OF DISTINCTION**

The 966 AACS organized and led the first-ever “FTU Safety Month,” – 15+ month-long events set the wing benchmark for mishap prevention and safety training. They organized briefs from the FAA Safety Team to train 300 instructors/flight crew on local area aviation hazards and mishaps in an effort to minimize the threat of midair collisions. Leadership mentoring sessions with the WG/CV and MKGCC were held to instill a foundation of safety culture to both IQT students and instructors. Egress training was given to 25 IQT students, simulating ground fire evacuation on an E-3 training jet with real-time fire department support. The 966th also conducted an internal MARE, training 190+ personnel and providing lessons learned for the ongoing revision of wing procedures. Furthermore, they took the lead during the combined-wing MARE as the EOC representative, in which base mishap response procedures were refined for the upcoming air show/80,000+ spectators. After a severe hail storm, the 966th led the way for a combined MX/ops FOD walk and damage assessment of 18 E-3 aircraft – flying ops were resumed within 24 hrs! The wing standard was set in FOD free, supporting their wing Sentry FOD program. The 966th was also responsible for 44+ pre-flight FOD walks around E-3s and 110 vehicle FOD inspections. They held weekly student safety briefs for 800+ students, establishing introductory curriculum on vital flight/ground safety topics for 33 different aircrew syllabi.
Sgt David T. Meyers greatly contributed to Air Force-wide weapons safety by developing two processes that were selected to become Air Combat Command benchmarks. Both of his innovations are being incorporated into the syllabus for the Weapons Safety Program Managers course. First, he developed an electronic database that greatly improved the accuracy of ammunition and explosive storage licenses. This database allows for electronically coordinating new Explosive Facility Licenses through the Fire Department, Security Forces, and the Munitions Accountability System Officer. This electronic coordination process reduced staffing time from months to less than a week. Without TSgt Meyers' process, first responders and munitions personnel were exposed to unnecessary risks due to outdated information on stored explosives. Second, TSgt Meyers reduced unnecessary exposure to explosive hazards by revamping the format for explosive storage justification letters. His new method clearly identified the number and types of munitions required to support the mission based on the number of students, classes or exercises a particular storage location supports. In use for over 6 months, this new format allows for a better determination of how many munitions should be stored in a given location and avoids unnecessary storage of excess munitions. TSgt Meyers' exceptionally innovative efforts as Weapons Safety Manager have greatly improved Weapons Safety across the Air Force.

Flight Line Safety

As the safety focal point for the 966 AACS Formal Training Sq, Capt Rains and TSgt Hamar brought to the attention of wing leadership that exterior skin paint of three E-3 AWACS had been peeling up and bubbling around aircraft static ports. This condition adversely affects the accuracy of the pilot static system, resulting in degraded altitude reporting and a resultant disqualification of RVSM certification. The RVSM capability allows the aircraft to operate at higher altitudes and thus save fuel. Additionally, in response to anti-skid malfunctions causing blown tires on landing in two separate E-3s, they set up a tracking and log system to provide inputs to wing Safety involving past and current similar incidents. They also laid the groundwork for open safety discussions involving actions to take if a tire blow-out occurs during landing or taxi. Working with several squadron agencies, they educated the 966 AACS on a recent mishap involving a high-speed E-3 takeoff abort where the crew was required to egress the jet on the runway utilizing the emergency slides. During the egress, the escape slide for aft crew entry door separated from the aircraft before any crewmembers could use it. In response to the failure of the slide, Capt Rains and TSgt Hamar advised the Sq crewmembers to closely inspect the stitching and supporting attachments prior to flight. They recommended the advanced inspections be taught to all new initial qualification students.

Weapons Safety

AWARD OF DISTINCTION

TSGT David T. Meyers
366th Fighter Wing
Mt Home AFB, Idaho

JULY / AUGUST 2008

THE COMBAT EDGE

TWELFTH AIR FORCE
Capt Adam C. Fisher
358 FS, 358 FW
Davis-Monthan AFB, Ariz.

388th Range Squadron
388 FW
Hill AFB, Utah

TSgt Lester O. Robertson
355 LRS, 355 FW
Davis-Monthan AFB, Ariz.

TSgt Tobin E. Petelo
355 EMS, 355 FW
Davis-Monthan AFB, Ariz.

1Lt Ty Walsh
Capt David Hamilton
391 FS, 366 FW
Mt Home AFB, Idaho

TSgt Jason P. Smith
432 OSS
Creech AFB, Nev.

TSgt Jason T. Martin
49 AXW, 49 FW
Holloman AFB, N.M.
ACC experienced three Class A flight mishaps in June and July. Two MQ-1s were destroyed in the AOR. Sadly, we lost six of our nation’s finest when a B-52 and her crew were lost near Andersen AFB, Guam. This year has seen a number of mechanical failures as well as human failures and their combinations. We have many adversities to safe flight operations: aging or malfunctioning equipment, logistics, maintenance, experience force structure, available training, fatigue, complacency, and a multitude of other human factors. Adding to our risk exposure, we have been operating in conflicts nearly continuously since 1991. We counter these threats with training, ORM, procedures, experience and mental/physical preparedness. Sun Tzu said, “Know your enemy and know yourself”; hence, know your weakness and strengths and fly accordingly.

ACC is halfway through the 101 Critical Days of Summer and the Command has experienced three motorcycle mishaps: a fatality, a Permanent Total Disability, and a Permanent Partial Disability. We must ask ourselves, “Is everything being done to ensure the safety of our units’ motorcyclists from the wing, squadron, shop, and Wingman perspective?”

First, let me say thank you for the hard work you are doing with your mishap prevention program. Please keep up the good work and positive trends. ACC has experienced only two mishaps in June and July. Both were attributed to equipment and procedures. The first involved an M-117 bomb which fell from a 40-foot trailer because of a broken weld on the trailer stop. The other involved a 5.56 mm round cooking off while an individual was in the process of clearing a jam on a M249 weapon. As a community, we’ve done great with curbing T.O. and directive violations that have led to mishaps; please apply the same diligence in spot inspecting other areas that could lead to potential problem areas. Keep up the good work and thanks for all you do for the Air Force.