*Spring Edition 2013*

# Combat Edge

*Air Combat Command's Safety Magazine*

## MORE THINGS FIGHTER PILOTS DON'T SAY

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*ACC Safety bids a fond farewell to Col. and Mrs. Mayeux as they walk off into the sunset*

# Combat Edge







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# ACCent

## OPERATIONAL SAFETY: WHAT IT IS, AND WHAT IT IS NOT

**Colonel Sidney F. Mayeux**
**Director of Safety**

Have you heard of Mayeux and Broussard? Google them. They're a fantastic new country/blues duo livening up the musical scene in Austin, Texas.

Wait. Somehow, "country/blues duo" really doesn't describe them accurately. Try this: Mayeux and Broussard are a "sonic roux" of swamp pop, rockabilly, and strong dirty bourbon, simmered slowly in the hot southeast Texas heat … all the best sweet flavors of Texas' music today.

If you know anything about Texas music and cuisine, then I believe my description gives you a good idea of what Mayeux and Broussard's music *is*. And from that, you can accurately guess what Mayeux and Broussard's music *is not*. It's not rap, not top 40, and that Bieber kid won't sing Mayeux and Broussard's music any time soon: That's what Mayeux and Broussard music *is not*.

Three springs ago, while I was the Air Force Safety Center's Chief of Aviation Safety, the commander of Air Combat Command hired me as ACC's new Director of Safety. COMACC said he wanted me to increase the level of cooperation and understanding between Operational Safety (ACC) and the many levels of support and oversight below and above our level, so that others might better understand and support CAF MAJCOM and Numbered Air Force commanders and their operational needs.

In my 2.69 years as ACC Director of Safety, I am now just about the ONLY Air Force colonel to serve at nearly ALL levels of safety — squadron, wing, MAJCOM, Safety Center, and Pentagon. Riding down this trail, I have refined crosshairs on what Operational Safety truly "*is*"… and "*is not*." Here's a great example regarding Aviation Safety Investigations:

Which is more important … the product or the process? Aviation safety investigation at the Operational Level "is" all about the *product*. The "product" is the actual mishap prevention result, its recommendations, and the risk management strategies it uncovers. COMACC (someone we consider our foremost "*customer*") must weigh those recommendations and strategies against mission requirements, (un)available funds and resources, and the needs of the combatant commanders and warfighters who rely on the combat capability provided by this MAJCOM force provider. At the Operational Level, "safety" is about the ability to source, provide and preserve combat capability, and safely execute the mission … that's what Safety "*is*."

An Aviation Safety Investigation "*is not*" about the process. Investigators shouldn't have to burn such long hours trying to properly format report tabs, photographs, and nano-codes, stuffing the system with unused mishap data for data's sake, at the expense of hard deliberation and coordination with agencies that can actually fix the hazard. You know … prevent mishaps? When safety organizations believe it's about the *process*, then the *product* suffers, and so does our major *customer*.

Today, my boots carry mud from all bends of the Safety River, and I can report the following: ACC Safety has the right Operational Safety sight picture. We know what Operational Safety "*is,*" what it requires, who we work for, and who relies on us. We properly support and enjoy the support of, our Commander. My fellow MAJCOM safety directors can continue to rely on ACC Safety's wingmanship as we shepherd Operational Safety initiatives across all 26 aircraft fleets in ACC's lead command portfolio.

As I leave active duty for my sweet Texas, seeking somewhere trouble don't go, I can't wait to watch my nephew Tate's band in concert. After all, I love any dish cooked up with a roux, and I do love whiskey … that's what I "*is.*" Kelli and I hunger and thirst for the place we long to be, the ground that keeps us standing. I am proud of your ACC Safety team … we've got your back.

So I "*is*" gittin while the gittin's good. …

# MORE THINGS FIGHTER PILOTS DON'T SAY

BY MR. DANIEL A. SUROWITZ

A few months ago I watched a video with some fellow fighter aviators. It was loosely called "Stuff Fighter Pilots Don't Say," and it was posted by some creative folks from the 354th Fighter Squadron at Davis-Monthan Air Force Base, Ariz. In the video, fighter pilots say phrases that one might hear anywhere in casual conversation — anywhere but in a fighter squadron. You won't hear them because it's not part of the culture. How do you know when a fighter pilot is in the room? They'll tell you. That is part of the culture. These are highly motivated, highly skilled and very competitive individuals. They focus on continuously sharpening their skills and raising the level of the game for themselves, their wingmen, their unit, commander and country. That competitive nature and keen focus on mission accomplishment exists throughout the Combat Air Forces. That focus is so intense that every other task or duty competing for attention is a distraction. It is our culture.



Photo by: Master Sgt. Ben Bloker


Photo by: Master Sgt. Ben Bloker

Here's another phrase you don't hear much in a fighter squadron: "I filed another ASAP (Aviation Safety Action Program) report today." ASAP offers an anonymous self-reporting tool for potential safety concerns. That too, is not part of our fighter culture, but it can be. I know what you're thinking — we already review everything that happens during a mission in the debrief. ASAP can supplement the time-honored debrief by sharing potential mishap precursors beyond the briefing room walls, and facilitating an objective review of those potential hazards.

The mission debrief is a key element of a fighter pilot's cultural DNA. During this sacred ritual, every brain cell and recording device is used to recreate and examine the mission in excruciating detail. We carefully draw engagements with colored markers, and frequently spend every minute remaining before entering crew rest discussing the fine points. We close the doors, de-emphasize rank, and proceed without interruption until completion. Often lasting longer than the mission itself, the debrief dissects each mission segment into its basic elements. We review administrative tasks separately from tactical execution. We critique radio calls and formation positions, and always offer recommendations for improvement. Safety, Rules of Engagement (ROE)/Training Rules (TRs), and Special Interest Items (SIIs) receive their own special place. For a routine mission with no significant problems, the ROE and SIIs are covered quickly. They are special, however, because a deficiency in any of these key areas could have serious consequences if not addressed immediately.


The debrief focuses on the core of the mission — the tactical execution. Shots or weapons delivery parameters are examined with the finest attention to detail, and using established tactics, techniques, and procedures, along with the wisdom of experience, the flight lead or instructor ensures all areas are addressed. All flight members leave the debrief knowing what they must do to sharpen their skills, or if necessary, to bring one's game up to acceptable standards to remain on the team. A successful debrief addresses everything worthy of discussion and leaves no questions unanswered.

Occasionally, the debrief reveals a situation or issue that should be shared beyond just the flight members. Deviations that affect safety, ROE/TRs and SIIs, as well as local procedural problems, should immediately be brought to an operations officer, commander or an appropriate safety or stan/eval member for action. That is the flight lead's job. Events that meet proper criteria may also require other reporting, such as a Hazardous Air Traffic Report (HATR). The traditional debriefing process, along with following established safety/hazard/stan/eval reporting should ensure that all appropriate items are addressed, reported, and shared with the right agencies. But what if something was missed?

How can that happen if the mission was thoroughly debriefed and all questions answered? All 781 write-ups were completed and discussed at the maintenance debrief. Any events meeting reportable criteria were reported, and issues requiring more horsepower were brought to the squadron supervision. What doesn't meet reporting criteria, but could have resulted in a mishap if not for some intervention or twist of fate? One possible answer would be a close call or what we often call a near miss.

Events happen every day that are not reported because they are "not that important." No one got hurt, and no rule was broken. They aren't covered in the debrief, perhaps due to significance or perhaps due to time. They may not even be remembered until after leaving the squadron. Maybe an individual does not want to confess to an error made in the privacy of his own jet due to fear of ridicule during the debrief from flight members. Have you ever heard of an aviator who spent a little too long heads-down in the cockpit and looked out just in time to avoid hitting another jet? Have you ever observed one of these "almost" events or actions where someone else committed the behavior and you said nothing?


Photo by: Master Sgt. Ben Bloker

I have had the opportunity to review countless mishap briefings of every class with some of our most experienced and wise CAF leadership. Many of these seasoned veterans have shared the lessons they learned after "surviving" near misses. Many have also spoken of the opportunity to take some action after observing some of these behaviors, whether the opportunity was taken or missed. As a community, we can do a better job capturing and learning from these close calls to help identify potential mishaps before they occur, and perhaps not wait until after the condition is experienced again, or the behavior is repeated resulting in an actual mishap.

While we have focused on our traditional practice of debriefing and telling stories of our "close calls," other communities have focused on these events and have even developed a web-based tool for anonymous self reporting of close calls. Yep, it's on the internet, at www.safety-masap.com. It's called ASAP. You go to the website, fill out the form and hit send.

Photo by: Tech Sgt. Matthew Hecht


## From the U.S. Air Force ASAP website

"ASAP is a program designed to enhance aviation safety through the prevention of accidents and incidents. It is an identity-protected, self-reporting system that encourages the voluntary reporting of operations and logistics/maintenance safety issues and events. It is designed to provide a non-punitive environment for the open reporting of safety concerns and information that might be critical to identifying precursors to accidents. These safety concerns may be either observed or experienced by the submitter. The goal is to prevent mishaps by addressing those unintentional errors, hazardous situations and events, or high-risk activities not identified and/or correctable by other methods or through traditional safety reporting sources. The reported information is used to reduce mishaps through operational, logistics/ maintenance, training and procedural enhancements."

ASAP is intended to provide a non-punitive method to self report unintentional errors. It will not provide immunity in cases of willful disregard of regulations and procedures. ASAP encourages reporting personal errors that could lead to a mishap or incident. These include unintentional errors by others, including air traffic control, crewmembers, and other flight members, which resulted in a "close call." One can report any unsafe action event or condition encountered during any portion of a flight or mission, or any hazardous situations not reported by other methods, such as safety reports or HATRs.

Here's how it works in Air Combat Command (ACC). An individual goes to the web site and fills out the report. The de-identified information is forwarded to ACC Safety, where a team of safety and MDS specific operations or maintenance subject matter experts review the individual reports and either assign corrective action or track the events to look for potential mishap precursors or trends. ASAP does not relieve individuals from mandatory mishap or HATR reporting requirements, and it is not a way to bypass the 847 process for changing publications. Where there is already an established process to report a problem or deficiency, and make a recommendation, it should be used. However, for those events that one feels should be addressed, but did not quite make it to the officially required reporting level, ASAP offers a means to record what happened and get the information out to a broader audience.

ASAP is relatively new to most of the fighter community. There have not been a lot of ASAP reports generated by CAF aviators, but it has proven successful in other communities. Using this method to report potential safety concerns has not been part of our safety culture. We have been comfortable putting all things out on the table during the mission debrief. We expect progress to be slow, and it will take time to weed through the first ASAP reports. Still, as we gain more experience with the process, we will be able to share more data, find common areas, and perhaps take the necessary steps to eliminate some hazards before someone is injured or property is damaged. Looking into what might go wrong, rather than what did go wrong, has not always been a part of our culture. ASAP is one tool that may help shift from mishap reporting to mishap prevention. It's time to bring that focus into our safety culture.

Photo by: Tech. Sgt. Lesley Waters

# CONTROL *before* PERFORMANCE

## the fighter MFOQA program

BY MR. BRIAN GRASKY AND LT. COL. ANTONIO CORTÉS, PH.D.

Psychologists tell us that what holds our attention is what determines action. Unfortunately, what holds our attention isn't always what should determine our action. Our attention is easily seduced by what we *believe* are pressing issues, but in *reality*, we often don't know the gravest safety threats. In order to detect and study operational hazards in the F-16, the Air Force Safety Center recently commenced analyzing F-16 flight data as part of the Military Flight Operations Quality Assurance (MFOQA) Program.

The MFOQA approach to safety management is similar to the control and performance concept in flying that is taught during undergraduate pilot training. Ever since we showed up for undergraduate pilot training, pilots have been taught to use the control instruments — the attitude indicator and power instruments — to control the aircraft, and the performance instruments — altimeter, airspeed indicator, vertical velocity indicator, heading, and angle of attack scale — to monitor aircraft performance.

As pilots, we take great pride in flying precisely. However, in the safety world, we all too often rely on gut instinct and personal perception of hazards. We can't individually detect all significant hazards and often neglect invisible threats because we are focused on those hazards that appear imminent and dangerous. We focus on 'performance instruments' of safety such as results, mishaps, after-action reports, and neglect the controls that cause these results.

Pilots are often unaware that a mission is drifting towards disaster because they lack the means to detect the numerous weak signals of failure, trends or close calls that precede most mishaps — the chain we speak of cutting that may lead to a mishap. For example, let's contemplate the difference that a few inches can make in our profession: An aircraft can come within a few inches of scraping a tail on landing, but if no sparks are made, no one will hear of the event. However, if a tail actually scrapes on landing, even if by just a few inches, maximum dissemination of the event will occur. How can we ethically allow a few inches to determine whether an event recedes into obscurity or flashes across a commander's desk? After all, the unsafe acts and conditions that went into the near-scrape are probably identical to those that resulted in the actual scrape. The only difference between both scenarios is luck. Can we call ourselves safety professionals if we allow luck to dictate the terms of our hazard reporting?

***What if we can see trend information for those close calls?***

Photo by: Senior Master Sgt. Kevin J. Gruenwald

Photo by: Airman 1st Class Brett Clashman

Over the past decade, the U.S. Air Force, and just recently, Air Combat Command, has implemented a scientific approach to uncover the weak signals that precede mishaps. We have implemented a program to look at the control side of mishap prevention in an effort to proactively take control of hazard reporting. MFOQA is a military version of the civilian Flight Operational Quality Assurance (FOQA). Whatever we choose to call it, the idea is to routinely download flight data in order to detect mishap precursors. FOQA is not a new program. It originated with British Airways in the 1960s. Academic researchers have documented significant decreases in mishap rates and maintenance costs at those airlines that have started flight data programs when compared to other air carriers that do not analyze flight data. The U.S. Federal Aviation Administration estimates a net savings of $892,000 per year for each 50 aircraft flown in FOQA programs. This partly explains why over 40 civilian companies in the U.S. have FOQA programs and why foreign airlines operating aircraft with maximum takeoff weights in excess of 60,000 lbs have flight data monitoring programs. The U.S. Navy has used MFOQA for years to detect mishap precursors on the Super Hornet and the Royal Netherlands Air Force recently started MFOQA on the F-16. More analysis and more data will find new and better use of the data as we move forward.

Philosophically, the great challenge of mishap prevention is that safety is often defined by the intensity of its absence. In other words, we often try to manage safety by measuring the rates of mishaps. Smoking holes are, rather tragically, the traditional metric used to measure safety. Unfortunately, they are trailing indicators of safety or it is like flying by the performance instruments. MFOQA allows us to use the control instruments, to actually measure the leading indicators of safety by examining close calls, which we know occur in far greater numbers than actual mishaps, and thus furnish our analyses with far more data than what our infrequent mishaps provide. With the trend data from the *almost mishaps* we can measure our drift towards failure instead of just the actual failures.

In the decade since commencing our MFOQA initiative, the USAF has learned to value the analyses produced from flight data. Aircrew flying MFOQA aircraft can learn the latest hazards at deployed locations and use such information to brief threats and errors germane to unfamiliar airfields, terrain, air traffic control and navigation. MFOQA analyses can be used to validate the effectiveness of tactics, training and procedures by measuring what actually happens during flight operations, versus what we think is happening. Actual aircraft performance data can be used to validate or correct calculated performance figures. Insights can be gleaned on how tightly flights are following mission profiles. Safety officers can learn what airfields are associated with a high volume of wake turbulence and what locations are triggering the most ground proximity warning system alerts. Flight profiles can be examined to discern where asymmetric over-Gs and transient over-temps are most likely to occur. We can also identify and trend "nuisance" faults that typically get overlooked and identify aircraft that might have a minor hardware or software malfunction before it becomes a large malfunction. Analysts are also able to determine whether procedural changes have improved operations or made things worse. In a nutshell, MFOQA allows us to make information-based decisions, instead of relying on our gut instinct, which is often wrong.

ACC and Air Education and Training Command's MFOQA program is overseen and promoted by the USAF Safety Center at Kirtland Air Force Base in Albuquerque, N.M. Currently, only select F-16s and the T-6 join the majority of "heavies" that participate in the program. Four prerequisites must be met in order to participate in MFOQA: an aircraft must have the ability to record the proper types of flight data, an experienced pilot trained in the MFOQA processes must analyze the data to detect mishap precursors, the command structure must know how to use the resulting analyses to manage risk, and a safety culture must exist that protects aircrew when errors are made.

In order to promote the proper use of flight data and to ensure the program is not used to punish aircrew, the Office of the Secretary of Defense published a memo, *Military Flight Operations Quality Assurance (MFOQA) Process Implementation,* dated Oct. 11, 2005. This memo states that data generated from the MFOQA process shall not be used for monitoring aircrew performance to initiate punitive or adverse action, except for cases of suspected willful disregard of regulations and procedures. The Secretary of the Air Force included identical language in AFPD 90-13, *Military Flight Operations Quality Assurance.* We go to great lengths to ensure that MFOQA is a non-punitive program. We accumulate data from many flights and de-identify the data before we try to detect instances where aircraft operated outside of preset parameters. We are especially interested in finding unsafe latent conditions, such as normalization of deviance or poor actuation or equipment limitations that may point to poorly designed procedures. We work closely with human factors experts to determine root causes of the mishap precursors detected by MFOQA.

Photo by: Staff Sgt. Henry Hoegen

This is an opportunity to get back to the basics. As in the cockpit where we fly off the control instruments and get resultant data from the performance instruments, MFOQA allows the fighter community to potentially see situations that lead to mishaps before they happen, rather than looking at why they happened. Let's use this to manage flying programs using controls rather than by watching the performance after the fact.

Photo by: Senior Airman Brittany Y. Auld

# KING 21 ...

# BREAKAWAY

# BREAKAWAY

# BREAKAWAY

Photo by: Tech. Sgt. Jeremy T. Lock

**BY LT. COL. DAVID R. MACKENZIE**

To the crews of Air Force HC-130P "Combat King" and HH-60G "Pave Hawk" rescue aircraft, these shocking words bring terrifying concern and stress the immediate need to separate the Helicopter Aerial Refueling (HAR) aircraft in order to avoid a disastrous in-flight collision. BREAKAWAYs are usually a result of an aircraft malfunction, in-flight hazard or excessive closure rate that would place one or the other refueling aircraft in a dangerous position that could, if unabated, compromise flight safety and lead to an in-flight collision. To our partners in the joint and coalition worlds, these same words can bring sheer fear and confusion due to unfamiliarity, different native languages or non-standard "host nation" procedures. Add in combat stress, environmental fatigue-like desert heat, or low visibility coupled with using night vision goggles and the pucker factor in both aircraft executing the in-flight ballet becomes more than just an "E-ticket" ride.

## Most of the time, flying the workhorse C-130 Hercules is smooth and predictable. Other times, it can be down-right challenging!

In late August 1995, an HC-130P crew assigned to the 71st ERQS supporting combat missions in the area of responsibility was tasked with what they believed was a "good deal" routine joint aerial refueling tasking supporting USMC CH-53E Super Stallions. In order to validate downed pilot recovery planning for very deep penetrations into downtown Baghdad (such as those later seen in Operations Desert Thunder and Fox the first operational use of B-1B Lancer in a combat strike role), the Leathernecks prepositioned three-engine Super Stallions to Aqaba, Jordan, near the Suez Canal. Utilizing Marine Tactical Recovery Aircraft and Personnel (TRAP) tactics (NOTE: a similar Combat Search and Rescue-type mission utilized by CH-53s in Bosnia in 1995 and MV-22Bs in Libya in 2011), the fuel-hungry receivers would have to meet up with their critical helicopter tanker to pull off the plan.

Prior to beginning the attempt to conduct the longest un-refueled helicopter flight to date, the two Sea Stallions lifted off and were quickly joined by the Combat King to begin the choreography of an aerial rendezvous to system check their air refueling systems should they be needed. The idea was that the lead Marine aircraft, newly modified with extended range fuselage "belly" tanks, would fly un-refueled from Jordan to Bahrain. This would validate the capability to execute the "downtown Baghdad" and return mission from anywhere in the AOR should the need arise. After testing both CH-53's refueling systems with token fuel off loads, the mission proceeded uneventfully for two-and-a-half hours until the second support helos' planned helicopter aerial refueling point. King 21 commenced the rendezvous with the Stallion flight along the Iraqi border near Rafha, Saudi Arabia and the helos lumbered into the PRECONTACT refueling position on King's left side. While a typical Pave Hawk's right side refueling probe is only 33 feet behind the tanker's tail with the 54-foot rotor disk being as little as 25 feet from the Herk's horizontal stab in a stable position, the larger CH-53E's 79-foot rotor can be as little as 15 feet away from contacting. Careful attention to detail and high proficiency in this very perishable skill is required in order to execute a successful CONTACT between the helo's extended probe and the tanker's oscillating 27-inch drogue and the passing of critical fuel.

Having been assigned heavy lift combat support roles for most of their deployment time, the Marines quickly found that their aerial refueling skills had atrophied. After nearly one hour of unsuccessful probe-to-drogue CONTACT attempts due to their low HAR proficiency, moderate heat-induced turbulence and fatigue, the Super Stallion requested a CROSSOVER to the right side of King in order to try and finally CONTACT the right side drogue. The right side drogue presents vastly different aerodynamic forces being present as a result of the helo being much closer to the HC-130 due to the helo's right side probe forcing only about 10 feet separation between the spinning rotors and side fuselage/tail surfaces. Another few unsuccessful CONTACT attempts on the right side raised the frustration level and pucker factor as the remaining fuel state began to rapidly dwindle and threaten mission abort. As the attempts ticked up and the fuel state dropped down, the now obviously overworked pilot pushed closer for a final attempt to place the bouncing probe into the oscillating drogue. With no warning, the loadmaster radioed from the ramp those chilling words of **"BREAKAWAY, BREAKAWAY, BREAKAWAY,"** to quickly separate the converging flying machines. Unfortunately, the call had come too late, as the massive helicopter's supersonic spinning rotors tore through the canvas and aluminum drogue while slicing the tankers dancing refueling hose and sending chunks of metal into the lumbering Herk's vertical tail. As quickly as contact was made, the helos started to diverge from their entangled embrace and the rotor hub strained to adjust to the increasing vibrations from the seven delaminating titanium blades. Luckily, the Stallions were able to make a controlled emergency landing at Rafha airport quickly followed by the wounded King. Ground examination of both aircraft revealed pieces of the cut off drogue coupling firmly implanted into the HC-130's tail, along with beer can size holes and the delaminating of all the helicopter's life lifting blades. Mishap testimony from a KC-130 pilot observer on board the King bird stated that the incident was a result of a "poor proficiency helo probe-to-drogue contact attempt" in moderate turbulence. Low helo air refueling proficiency had doomed the mission for failure, but skillful emergency procedures training helped the crews survive this mishap.

After Operation Southern Watch and having been deployed to Italy, Kyrgyzstan, Kuwait, Pakistan, Saudi Arabia and Turkey in support of Operations Allied Force, Iraqi Freedom and Enduring Freedom, HC-130s continue today to support commitments in Afghanistan and the Horn of Africa where the harsh environments continually test their perishable air refueling skills. As Air Combat Command has been forced to reduce home station flying hours and deal with the corresponding lower proficiency levels, crews have welcomed the deployed opportunity to utilize the near endless overseas contingency operations funded flying to hone and practice their mastery of the in-flight fuel exchange. However, maintaining flying proficiency utilizing NVGs for tactical flight profiles to avoid detection to accomplish infiltration/exfiltration and transload operations at low altitudes in contested or sensitive environments, has come at a cost. "Sitting" PR/



Photo by: Airman 1st Class Veronica Pierce

CSAR alert causes critical flying skills to atrophy. Coupled with having a coalition or joint partner not postured to maintain those qualifications and currencies can be a recipe for mission failure and disaster.

Unfortunately, a January 2007 Combined Joint Task Force Horn of Africa (CJTF-HOA) sortie would bring back memories for some of the crewmembers of those difficult refueling attempts near Rafha more than 11 years earlier. Such was the case when the 79th ERQS Desert Knights found some Marine heavy airlift helos wanting fuel but finding that their previous training attitude of "I would rather suck fumes than HAR," would on this day cost them not only mission failure, but a cold, tense night spent at an unplanned bivouac site surrounded by non-friendlies.

The pair of CH-53Es trained for heavy airlift support of Marine Air Ground Task Force had been tasked in their secondary role of TRAP to support Africa PR requirements due to their inherent HAR and long range capabilities. When the Ironhorses of HMH-461 received the execute call to pre-position to support possible anti-pirate operations in and around Somalia, they knew it would require multiple aerial refuelings from the Knights. After multiple refueling CONTACT attempts were unsuccessful, depleting fuel reserves forced the Marines to land at an abandoned airstrip and the tankers to abort the mission until the next day. Ultimately, the helos were able to execute the refuelings and stage into position, but their redeployment would have to be conducted by transiting aboard a passing landing helicopter dock amphibious assault ship for their transit back to their deployed base. The lesson learned or in this case, relearned, was that low proficiency in mission-critical skill sets can result in mission failure or worse! Every flying hour must be utilized to its' utmost potential so we can have mission success and fly safely!

Photo by: Airman Natasha Dowridge

# AWARDS OF DISTINCTION

## Aircrew Safety

**CREW OF BONE 23, 37 EBS, AL UDEID AB, QATAR.** As the crew checked in and received the first of two nine-line targeting requests, a critical on-board navigation computer failed. As they maneuvered the aircraft for bomb run prosecution, the crew noticed smoke and fumes entering the cockpit. They determined they had to remain at altitude in order to execute an immediate air strike to protect friendly ground forces under the constant barrage of enemy fire. The crew declared an emergency and safely recovered the $283M aircraft without incident. *(Awarded Nov. 2012)*

**CREW OF ZORBA 37, 41 EECS, BAGRAM AB, AFGHANISTAN.** As the main landing gear of the EC-130 touched down 1,510 ft down the runway, a tug was noticed moving on Taxiway Foxtrot, 1,000 ft from the touchdown point and 2,800 ft from the threshold. The tug driver crossed into the active runway directly in front of Zorba 37 as the aircraft sped down the runway. With zero margin for error and a split second to react (with the nose gear still airborne), the throttles were firewalled in an attempt to gain altitude and safely execute a go-around. The crew's quick thinking and flawless CRM skills prevented a Class A mishap and catastrophic loss of a communication jamming LS/HD platform valued at $162M. *(Awarded Dec. 2012)*

**CREW OF LANCER 64, 333 FS, SEYMOUR JOHNSON AFB NC.** Lancer 64 experienced a fuel transfer pump failure about 20 minutes into a four-ship F-15E training sortie. Maj Olthoff and Capt Sisler directed their element lead to conduct a battle damage check on their aircraft and executed the appropriate checklists before splitting from the formation. The crew realized the brake malfunction, coupled with the construction on the shortened single runway, meant they would have to make an approach-end cable engagement. The crew finally executed a textbook approach and landing to a displaced threshold. Their systems knowledge resulted in the safe return of aircrew, a $54M combat asset and safe aircraft recovery. *(Awarded Jan. 2013)*

## Crew Chief Safety

**AIRMAN 1ST CLASS DUSTIN C. SMITH, 23 AMXS, MOODY AFB GA.** During his inspection of an A-10C's right speed-brake system, Amn Smith identified a hydraulic fluid leak coming from the area. He notified his flight line expediter and reported his findings. He determined the origin of the leak — a cracked speed-brake actuator line. He removed and replaced the damaged line with a locally manufactured one. While installing the replacement line, he noticed it was incorrectly bent and was rubbing on the speed-brake surface. He removed the line and had the line correctly bent and installed it, preventing a catastrophic mishap. *(Awarded Dec. 2012)*

**SENIOR AIRMAN BRIAN S. CHATHAM, 4 AMXS, SEYMOUR JOHNSON AFB NC.** While performing fire guard duty during a routine maintenance run on an F-15, Amn Cheatham noticed sparks coming from a wire bundle forward of the right integrated drive generator. Through quick and decisive action, he utilized a flight line Halon fire bottle and extinguished the flames. Afterwards, he secured and monitored the area and aircraft until the fire department arrived. Post incident inspection revealed his actions prevented damage to the generator, two hydraulic pumps and the airframe mounted accessories drive — parts valued at over $100K. *(Awarded Jan. 2013)*

## Weapons Safety

**SENIOR AIRMAN AARON C. STOVER, 49 MXS, HOLLOMAN AFB NM.** Amn Stover identified a documentation error on the 24-month static bond continuity checks. Armament personnel utilize this system to ground themselves and equipment prior to performing maintenance tasks involving explosives known as EEDs, thereby preventing static discharge that could initiate these devices. He noticed that the test points illustrated on the static ground system diagram were inconsistent with the last documented tests. His quick actions verified the integrity of the system, ensuring work and facility safety. *(Awarded Nov. 2012)*

**STAFF SGT. CARLA M. RASTEDE, 26 ERQS, KANDAHAR AF, AFGHANISTAN.** Sgt. Rastede identified a major explosive safety violation during a routine storage inspection. While stockpiling munitions, she recognized the net explosive weight for hazard class/division 1.1 was exceeded. After identifying an excess of 31 munitions on the Operations Custody account, she immediately divided the operations and pararescue 1.1 munitions between the explosive facility and the munitions storage area to mitigate any risk. Her efforts significantly increased efficiency of munitions egress. *(Awarded Dec. 2012)*

## Weapons Safety

**STAFF SGT. SHAUN D. PETTIS, 455 EMXS, BAGRAM AB, AFGHANISTAN.** Bagram A-10 pilots reported several LUU-19 flares utilized during ISAF missions were not igniting when deployed in-flight. Sgt. Pettis was chosen to lead an in-depth investigation on 29 SUU-25 flare dispensers loaded with 8 ea LUU-19 flares. His expertise led to his discovery of a critical malfunction on the ADU-381 flare adapter kits. Sgt. Pettis' performance and safety discipline reduced future misfires of the LUU-19s during flight and thereby possibly averting a catastrophic mishap. *(Awarded Jan. 2013)*

## Flight Line Safety

**MR. MICHAEL FERMAN, 355 OSS, DAVIS-MONTHAN AFB AZ.** While directing operations as tower controller, an F-16 (Gator 01) with limited fuel was approximately one-half mile from landing threshold, he spotted a coyote on the runway, approximately 3,000 ft from landing threshold. With seconds before the aircraft's landing, he took immediate action to provide Gator 01 go-around instructions. After scanning the runway surface area for wildlife and unauthorized vehicles, Mr. Ferman cleared Gator 01 for landing, leading to the F-16's safe recovery. *(Awarded Nov. 2012)*

**MR. FRANK L. LUCAS, 355 OSS, DAVIS-MONTHAN AFB AZ.** While a flight of two A-10s were returning to D-M, Mr. Lucas spotted a Cessna 206, which was under radio and radar control with Tucson TRACON. The Cessna was orbiting over I-10 at 6,500 ft, two miles ahead, and in the direct flight path of the descending A-10 flight. He then issued traffic information to Possum 01 and instructed the A-10s to maintain 7,000 ft, despite the fact that the a/c had not yet entered tower-assigned airspace. His decisive actions eliminated the potential for a catastrophic midair collision! *(Awarded Dec. 2012)*

**SENIOR AIRMAN ANSON A. HAYNES, 552 MXS, TINKER AFB OK.** Amn Haynes was performing system operational checks on the flight deck of an E-3 AWACS when he noticed a burnt electrical smell. He powered down the aircraft and ensured all personnel were evacuated from the area. Amn Haynes notified the dock supervisor of the malfunction and danger so technicians could remove the failing batteries. His situational awareness and experience allowed him to ensure the safety of personnel, prevent damage to the hangar, and avert further damage to the $330M aircraft. *(Awarded Jan. 2013)*

## Ground Safety

**AIRMAN 1ST CLASS ROBERT P. GERIAK, 20 CES, SHAW AFB SC.** Amn Geriak awoke to the strong smell of smoke and immediately reacted. Further investigation led to a small brush fire steadily moving towards the apartment complex. He located the nearest fire extinguisher and thoroughly sprayed the base of the fire until the flames were completely out. Due to his quick actions, more than 200 residents were spared potential loss of property, serious injury and even death. *(Awarded Nov. 2012)*

**AIRMAN 1ST CLASS MESHA L. SCHALL, 49 MMS, HOLLOMAN AFB NM.** Amn Schall was on site at the Bare Expeditionary Airfield Resources high-voltage tie-in with a fellow Airman conducting a check on a report of a leaking fuel line. While the other Airman went through troubleshooting steps, the fuel line burst, spraying the Airman in the face and saturating his clothing with diesel fuel. Amn Schall grabbed the disoriented Airman and pulled him to the emergency eye wash/shower facility. She flushed his eyes complete of the fuel. Her quick actions mitigated the various complications associated with fuel absorption into the body, including benzene poisoning. *(Awarded Dec. 2012)*

**STAFF SGT. ARTHUR F. BISHER, 366 CES, MT HOME AFB ID.** Sgt. Bisher organized a work center safety scavenger hunt to search and identify potential safety hazards that could lead to a near-miss or injury. Issues identified included an electrical cord with a ground plug removed, daisy chained power strips behind computer desks, and a coffee pot in an office on a wooden/combustible surface. Additional items discovered revealed an electrical fuse panel improperly labeled, and defective PPE provided near powered machinery. Sgt. Bisher used a creative solution to challenge his personnel to correct potential hazards while highlighting the importance of day-to-day safety awareness. *(Awarded Jan. 2013)*

# AWARDS OF DISTINCTION

## Pilot Safety

**MR. GERROLD G. HEIKKINEN, 82 ATRS, TYNDALL AFB FL.** After takeoff in a Q(R)F-4C Phantom, at an altitude of 100 feet and airspeed of 250 knots, the cockpit temperature began to increase intolerably. A mixing valve in the environmental conditioning system had failed wide open and was venting 600-degree C bleed air from the engine, along with smoke and fumes. Mr. Heikkinen made a 180-degree turn away from the shipping channel toward a clear area that could safely be used and jettisoned the centerline fuel tank into an unoccupied area of the sea, safely recovering and preserving a $2M asset. *(Awarded Nov. 2012)*

**1ST LT. ELI D. CULPEPPER, 74 FS, MOODY AFB GA.** While controlling multiple sets of fighters on a simulated strafe during an air strike control upgrade sortie, Lt. Culpepper's A-10C shuddered, started to yaw to the right with a simultaneous illumination of multiple caution and warning lights. He analyzed the situation as a compressor stall on his right engine. With airspeed rapidly decreasing, and the right wing starting to drop, he cross-controlled the aircraft. He executed the out-of-control procedures while calling the knock-it-off. His actions led to the aircraft's safe recovery. *(Awarded Dec. 2012)*

**CAPT. WILLIAM FLYNT, 55 FS, SHAW AFB SC.** Capt. Flynt expertly recovered his F-16 during a live fire aerial gunnery event with a hung gun. He was in position to execute a live banner strafe when he depressed the trigger and no rounds were fired. He checked inside the cockpit and confirmed that all the switches were in the correct position. TDY to Tyndall, he was not acutely familiar with the hung ordnance procedures, making his recovery more difficult. He nevertheless avoided overflying coastal towns and restricted areas during his recovery. His quick actions minimized risk to the local populace and saved a $25M combat asset. *(Awarded Jan. 2013)*

## Unit Safety

**9 MUNS, BEALE AFB CA.** The 67 Ammo professionals of the 9th Munitions Squadron continued their tradition of excellence and safety with another astounding mishap-free month. Their focus on 100 percent technical order compliance and zero-incident explosive handling operations seared safety into the minds of the youngest Airman to the most seasoned leader. The team moved more than 3,000 munitions assets, and more than 600,000 pounds of net explosive weight during break-out, assembly and delivery of more than 1,000 live bombs supporting 320 sorties during a four-day IRON FLAG exercise. *(Awarded Nov. 2012)*

**361 ERS, KANDAHAR AF, AFGANISTAN.** The 361 ERS Ravens flew 639 sorties, totaling 3,322.4 flight hours, resulting in an unprecedented 100 percent air tasking order completion rate with zero flight mishaps. They provided over-watch for over 5,000 coalition soldiers, and applied find, fix, finish support to over 30 ground units against Taliban fighters. These actions resulted in 34 enemies killed in action and the capture of 108 insurgents. Their safety day briefing educated and informed 144 squadron personnel with zero impact to mission completion. *(Awarded Dec. 2012)*

**380 EAMXS, AL DHAFRA AB, UAE.** During an inspection, team members discovered a damaged no. 2 spoiler and spoiler flange panel. Upon discovery of the damage, a thorough investigation of the entire area was conducted, isolating the root cause to faulty rivets on the leading edge of the spoiler flange panel. Had the damaged spoiler gone undetected and the aircraft been allowed to continue flying operations, the potential for further damage would have been mission-impacting. *(Awarded Jan. 2013)*

# QUARTERLY AWARDS

## Flight Safety

**2ND LT. CHRISTOPHER B. ALFONSO, 28 MXS, ELLSWORTH AFB SD.** Lt. Alfonso was called upon to be a technical expert for a C-130 Class A mishap that occurred near Ellsworth AFB. Within 18 hours, he was on-scene to assist in the recovery of the aircrew. Afterwards, he began the initial survey for support needed for sustained investigation and recovery operations. He personally recovered the flight data and voice records in minimal time, allowing the SIB to begin processing data to determine the cause of the accident. He immediately recognized a shortfall in home station capabilities and coordinated for specialized cutting and lifting equipment needed to gain access to the aircraft and reduce its size for transport off the mountain. Due to Lt. Alfonso's efforts, the aircraft was recovered in 19 days. He was also appointed as the investigating officer for a B-1 Class B engine damaged in the FOL. He pulled all aircraft and engine maintenance records, reviewing for causes of the mishap. He subsequently went to Tinker AFB to observe the engine teardown and reviewed contractor training records and procedures. His meticulous attention and tenacity for answers led him to identify five urgent action items, to include insufficiencies in training, communication, and accountability. Although the investigation is still ongoing, his immediate inputs have already increased visibility on engine inspections and maintenance, potentially avoiding future aircraft mishaps.

## Ground Safety

**TECH. SGT. JUSTIN T. DEVANEY, 366 SFS, MT HOME AFB ID.** Sgt. Devaney meticulously processed six ACC Form 164s following squadron mishaps this quarter and performed preventative measures. He authored and distributed briefings emphasizing safety awareness both on and off-duty. Sgt. Devaney led a 100 percent data-call across the entire squadron ensuring personnel participating in high risk activities had required safety briefings and associated training. Sgt. Devaney ensured all unit personnel were aware of new requirements found in AFI 91-207 and posted a motorcycle safety tri-fold at the installation gates, ensuring compliance for all riders base wide. He disseminated a safety video to over 163 personnel displaying the impacts of inattentive motorcycle riding. Next, Sgt. Devaney performed six no-notice spot inspections on SFS facilities throughout the installation identifying and fixing shortfalls with ACC directives and current wing policies. During the recent 366 FW safety stand-down, Sgt. Devaney designed and facilitated a robust "Defender Safety" event. With less than 36 hours notice, Sgt. Devaney orchestrated a one-hour combative orientation course and delivered an all inclusive end of summer and winter safety briefing. He skillfully organized three weapons safety instructors, teaching a two-hour defenders edge resiliency familiarization class where SF personnel learned how to safely manage adrenaline, sleep, personal relationships and post-combat thoughts and emotions.

## Weapons Safety

**TECH. SGT. SCOT A. SOLHEIM, 20 FW, SHAW AFB SC.** Sgt. Solheim's experience was instrumental in the development and implementation of an orientation program that provided local safety guidance to nine commanders newly assigned to the 20 FW. He consolidated multiple locally developed tracking and review documents into one database, saving countless man-hours. This provided a single repository to track annual reviews for 62 publications, 14 explosives facility licenses, and 27 ESPs. Sgt. Solheim surveyed and identified multiple electromagnetic radiation hazards throughout the installation that could potentially pose a risk to explosives. He coordinated and directed a full-scale MSA fire drill, validating evacuation, cordon, notification and firefighting procedures of all agencies, illustrating the complications of operating within a MSA. His keen eye and quick actions drove the efforts to correctly RAC the missile maintenance facility for being structurally unsound. Sgt. Solheim conducted a full review of the operating procedures on nearby Pointsett Electronic combat range, directly enhancing mission effectiveness for all 9 AF Air Combat Units. He also conducted base-wide wpns safety reviews; completing annual inspections and formal out briefs to SQ CCs for all base weapons safety programs. Finally, his professional reputation and knowledge led to accolades from the 9 AF Director of Safety for superb Airmanship during the 20 FW's ACC PME inspection.

# Best Practices
## IN ACC SAFETY MANAGEMENT

### Flight Safety Programs

***Specialized Flight Safety Staff***
*432 WG, Creech AFB — Feb 2013*
Dedicated Psychologist and Human Factors expert imbedded in Flight Safety to deal with unique mission related risks

***(Operational) Risk Management***
*432 WG, Creech AFB — Feb 2013*
Well developed/standardized quantitative ORM process; tracking of ORM scores accompanied with trend analysis; periodic review of reporting levels with commanders

***Trend Analysis***
*432 WG, Creech AFB — Feb 2013*
Excellent/thorough trend analysis of mishaps, use of master question files and tailored SEPT sessions to mitigate risk

***NAF/SE Self-Inspection Checklist***
*USAFWC, Nellis AFB — Oct 2012*

***Bird/Wildlife Aircraft Strike Hazard***
*55 WG, Offutt AFB — Jun 2012*

***Airfield/Airspace Encroachment***
*99 ABW, Nellis AFB — Feb 2012*

*These programs were recognized as best practices in Air Combat Command during Safety Program Management Evaluations. If you are looking to strengthen your Safety Program in one or more of these areas, these folks are doing it exceptionally well.*

*You can also find an expanded list of strong Safety Programs by becoming a member of the ACC Safety CoP at: https://afkm.wpafb.af.mil/hqaccsafety*

### Ground Safety Programs

***Traffic Safety Program***
*432 WG, Creech AFB — Feb 2013*
Coordination with wing leadership and the local community
- Rumble strips installed roadside on Highway 95 between installation and Las Vegas to aid in vehicle rollover prevention
- Safe pullover areas located off of Highway 95 between installation and Las Vegas

***Motorcycle Safety Program (Support)***
*7 BW, Dyess AFB — Jan 2013*
Totally engaged leadership, program supported from top down, taught by off-base contractor, funded by vouchers, mandates sports bike course

***Fall Protection Program***
*7 BW, Dyess AFB — Jan 2013*
Ground safety staff totally engaged in fall protection program, competent person trained, works hand-and-hand with squadron fall protection POCs

***Total Force Integration (AFRC / ACC)***
*388 FW, Hill AFB — Sep 2012*

***Interactive Unit Safety Representative Guide***
*388 FW, Hill AFB — Sep 2012*

***Program Management through the use of SharePoint***
*388 FW, Hill AFB — Sep 2012*

***Inspection/Assessment***
*55 WG, Offutt AFB — Jun 2012*
*99 ABW, Nellis AFB — Feb 2012*

***OJT/Upgrade Training***
*99 ABW, Nellis AFB — Feb 2012*

### Weapons Safety Programs

***Electro-Magnetic Radiation Analysis***
*4 FW, Seymour Johnson AFB — Oct 2011*

***Nuclear Certified Equipment***
*388 FW, Hill AFB — Feb 2011*

***Lightning Protection System (CE Involvement)***
*49 WG, Holloman AFB — Nov 2010*

***New Commanders' Orientation***
*23 WG, Moody AFB — Mar 2010*

***SEW Management Tool "The Brain"***
*23 WG, Moody AFB — Mar 2010*





## FY13 Flight

As of December 31, 2012

| | Fatal | Aircraft Destroyed | Class A Aircraft Damage |
|---|---|---|---|
| 1 AF | | | |
| 9 AF | | ✈ | ✈ |
| 12 AF | | ✈** | |
| USAFWC | | ✈** | |
| ANG (ACC-gained) | | ✈ | |
| AFRC (ACC-gained | | | |

## FY13 Ground

As of December 31, 2012

| | Fatal | Class A | Class B |
|---|---|---|---|
| 9 AF | 🧍 | 1 | 1 |
| 12 AF | 🧍 | 2 | 1 |
| DRU's | | 0 | 1 |

## FY13 Weapons

As of December 31, 2012

| | Class A | Class B |
|---|---|---|
| 9 AF | 0 | 0 |
| 12 AF | 0 | 0 |
| AWFC | 0 | 0 |

## Flight Notes

ACC started FY13 with Class A mishap numbers similar to last year. We have experienced one destroyed F-22 in November and a destroyed ANG F-16 in December. With pending budget and flying hour cuts across the AF, we urge units to continue to promote proactive safety programs. Anticipate areas that potentially contribute to mishaps and mitigate the risks before they bear fruit. Currency does not necessarily equal proficiency; ACC/SEF encourages supervisors and commanders to ensure individuals are proficient or being supervised until proficiency is regained.

## Ground Notes

Going into spring and this year's Critical Days of Summer, Air Combat Command has sustained three fatalities. The fatalities revolved around a motor vehicle in one form or another. The first fatality, a PMV2, occurred when an active duty member struck a vehicle that pulled out in front of him. The second fatality resulted when an Air Force member was involved in a physical altercation that spilled out onto a roadway. The Airman was struck by a passing vehicle and killed. The third fatality occurred when an Airman operating a PMV4 left the roadway for unknown reasons and was killed; he was not wearing a seatbelt. Like almost every mishap that occurs, these incidents were preventable. Especially if you examine the personal accountability of one or all of the individuals involved. Simply buckling your seatbelt, looking for cross traffic and most importantly not putting yourself into a bad situation can and will save a life ... maybe even yours.

## Weapons Notes

During the first quarter of FY13 ACC experienced four total weapons mishaps; two Class Cs and two Class E mishaps. Half of our mishaps were a direct result of violating technical orders. T.O. violations continue to be the leading contributor to weapons mishaps in ACC. We need to reverse this negative trend. Continue exercising mishap prevention measures and follow T.O.s to the letter throughout your day-to-day explosive operations. Thanks for all you do for the ACC weapons safety community.

### Legend

Class A - Permanent Total Disability; Property Damage $2,000,000 or more
Class B - Permanent Partial Disability; Property Damage between $500,000 and $2,000,000
Class C - Lost Workday; Property Damage between $50,000 and $500,000
*(Class Description Effective October 1, 2009)*

** Non-rate Producing  * Fatality

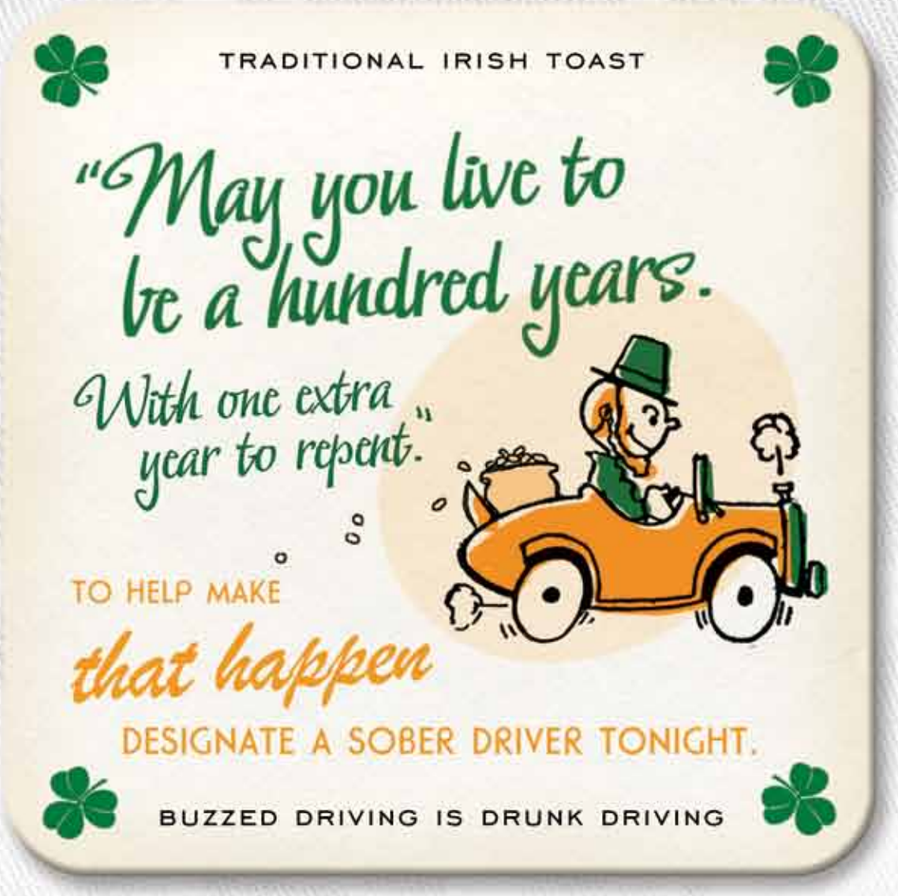
= Fatal  = Fatal due to misconduct

### Symbols for Mishap Aircraft

# OVER the Edge MAGAZINE


## the LIFESAVER

PAGE 4




OVER the Edge MAGAZINE

*We would like to say a special thank you to Mr. Greg Davis who shot and sent us our "Over the Edge" cover photo!*





# In real life, there is no Reset Button.

Riding a motorcycle is fun, but it isn't a game. Motorcycle riding demands your full attention. Even one drink can impair your coordination and sense of balance. Studies show that nearly half of all motorcyclists who died in solo crashes were under the influence of alcohol. They simply lost control of their bikes. Game over, forever.


MSF MOTORCYCLE SAFETY FOUNDATION®

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when you RIDE, THINK – don't drink.

# the LIFESAVER


BY AIRMAN 1ST CLASS KENNETH NORMAN

"When I woke up in the ambulance, the paramedic took my helmet and shoved it in my face and said **'if you hadn't been wearing this we would be scraping your brains up off the pavement and you would be dead,'"** Maj. Adam Travis recalled of a motorcycle ride that could have been his last.

Travis and Master Sgt. Lee Adkins were riding their motorcycles Jan. 15, 2012, in a group of five riders. The group was about 3 miles south of the City of Altus when Adkins collided with a tumbleweed at 70 mph and was thrown from his bike, which then caused Travis to crash.

"I saw huge tumbleweed out of the corner of my eye in the median," Adkins said. "I thought we were going to pass it because we were going 70 miles an hour and that is the last thing I remember."

"We didn't even break 5 miles out of town and a piece of tumbleweed comes from the opposite side of the road. The front rider pointed it out and everyone sees it," said Staff Sgt. Michael Fagan, the last rider in the group. "As soon as our lead rider passed the tumbleweed it rolled out into the road in front of Adkins. It looked like - from me seeing everything from the back — it hit his front wheel and exploded, and I'm thinking the tumbleweed slipped under his front wheel and brought it out. He goes down and then by reaction Travis locked up his brakes and went down."

"The last thing I remember seeing was this giant tumbleweed that was the size of a kitchen table come rolling out on the road as Leroy was driving through it," Travis said. "I woke up in the ambulance for about 30 seconds and then I woke up in the hospital a couple hours later and that is about all I really remember of it."

Adkins and Travis were riding in the second and third position of the group. They kept the proper distance between each rider, but at 70 mph it comes up fast.

"We were doing the speed limit, we were all far enough apart from each other, we were with other experienced riders, no one was doing anything unsafe, and we just had a very unfortunate situation pop up," Travis said.

Both Adkins and Travis suffered injuries, which could have been fatal if they were not wearing their PPE.

Photo by: Staff Sgt. Vernon Young

Photo by: Staff Sgt. Vernon Young

"I was wearing jeans, riding boots, leather jacket, gloves, smash resistant glasses and a helmet," Adkins said. "I was wearing a helmet and still fractured my skull. I had a brain bleed, shattered my forearm - had to have surgery on that, two plates, 12 screws — four broken ribs, punctured lungs, lacerated liver, torn medial collateral ligament, huge abrasion on the right side, which has had three surgeries, and a lot of ligament damage."

Adkins found out after the accident that emergency responders thought they might find him dead on arrival.

"The call went out to highway patrol as a possible fatality," Adkins said. "I didn't know that until a couple months after when the highway patrolman actually came to my house. If it wasn't for the gear, I wouldn't be talking to you right now."

Travis was wearing a full-face helmet made of carbon fiber. At some point during the accident he flipped over and started sliding on his face. The helmet still has pieces of tumbleweed embedded into it.

"My jacket, gloves, pants, boots and helmet — all of it got destroyed and the only thing I have to show of it is a tiny little scar on my thumb and backside from road rash," Travis said. "It absolutely kept me from dying."

Travis and Adkins are both back on flying status.

"Two of us that were wearing all of our PPE are still very much alive and very much back on active duty and flying status because of our PPE," Travis said. "If it had not been for our PPE, we would both be dead — no doubt about it."

PPE wasn't the only factor that saved Travis and Adkins. Staff Sgt. Daniel, Massey and Fagan, were the other members of the riding group and because of their actions Travis and Adkins are still alive.

Once Adkins and Travis stopped rolling down the road from the accident, the other three riders made sure they did not move and blocked the road off.

"Either of us could have had a spinal injury so if they had allowed us to get up or let someone else move us it could have been bad," Travis said.

"PPE and the Wingman concept really did come into play. It's not something that we thought was going to happen, but if you have the right training, when it does happen you can just snap right into it and let the training kick in."

Both riders highly encourage motorcyclists to wear their PPE.

"If you're not mature enough to understand the ramifications and implications of having a wreck without your PPE on, you don't need to be riding," Travis said. "It has nothing to do with your skill level or the skill level of the people riding with you. It has to do with the situations that you can't control."

"I am glad the AF makes you wear PPE because you don't realize how much of an impact it will have until something bad happens," Adkins said. "You don't want to wait until something happens to find out if PPE was necessary or not. Even with just the minimal requirements, you may need some more. It is a life saver — that is for sure."

Both riders said they will never forget how this accident affected their lives and the lives of their families.

*~Editor's Note:*
*Maj Travis' bike was totaled in the wreck; Master Sgt. Adkin's bike only suffered minor damage. Lee is still riding; however, Adam's wife laid down the law and said no more! Both of them are still flying and teaching students. They have some lingering effects from the wreck but are doing fine. In fiscal year 2012, ACC had a total of 75 motorcycle mishaps — seven of which were fatalities or led to total disability. So far this fiscal year, we've had one Class A fatality and 19 Class Cs. As the weather changes and the bikes are dusted off for a season of riding, let's be careful out there and keep the shiny side up!*

LUCKILY, IT ONLY COST ME A

# BRUISED EGO

**BY MASTER SGT. KEVIN L. SCOTT**

Winter was over; the snow had finally melted, so a few coworkers and I decided to go off-roading deep in the woods of Alaska. There's only one problem with this scenario — I had never been off-roading. As a matter of fact, the last time I had been on anything close to an all terrain vehicle was 15 years prior.

The day started fine and the guys who brought their ATVs were riding and having a good time while those of us who didn't own ATVs were standing around watching. Then they decided to try and climb a rocky mound which was around 10 feet high. All the riders were successful with their attempts and that's when it happened. One of my friends rode down and pulled up next to where I was standing and said, "It's your turn." I was reluctant at first, but with some kind "coercing" from the other guys, I decided to give it a try **(mistake No. #1)**.

So there I was staring up at my friends on top of the mound, about to try something I had never done before. Since each of them had done it with little to no trouble, I thought to myself, "How hard could it really be?" I was determined to make it on top, so I mustered up the nerve, took a deep breath, hit the throttle and cautiously started up the mound. A quarter of the way up, things were going better than I could have ever imagined and my confidence began to rise, so I decided to pick up speed **(mistake No. #2)**.

Halfway up, my right front tire hit a big rock, lifting the front of the ATV, and since I was on an incline, the ATV tipped backwards, subsequently causing me to fall off the back and sending me rolling down the mound. I eventually stopped rolling, only to be hit by the ATV, which had also been tumbling down the mound. One of the rear wheels landed on my hand, but I was fortunate because I was wearing gloves; however, it could have been worse because I was not wearing a helmet **(mistake No. #3)**.

I was able to walk away from this incident with only a bruised ego and minor damage to the ATV. All in all, I can say that this situation could have ended a lot worse than it did. And if there is anything that I could pass on to others from this experience it would be:

A new rider is more likely to make the wrong move or freeze up in an emergency scenario. The wrong move can include not wearing the proper safety gear. The temptation to "gun it" is powerful for a newbie, even though they have limited ability to safely negotiate the different challenges they may face.

While these reminders hardly scratch the surface of ATV safety as a whole, the main point is to ride smart and get home safe. Know your machine's limitations and more importantly, know your limitations as a rider. Finally, if there's a hint of doubt in your mind, don't let peer pressure override your gut feeling like I did. It's simply not worth it.

# DON'T BLOW IT

BY LT. COL. RODNEY NICHOLS

It was summer 1983 and I was 18 years young and looking forward to college in a couple of weeks. Saturday night at the local drive-in and my friends and I are going strong, drinking quite a few six-packs of beer. I know I'm drunk as I drive home, but I was 18 and thought that nothing was going to happen to me ... and nothing did. I woke up the next morning with a pretty good hangover to find my loving father standing in the kitchen. He greets me with a smile and in a booming, louder-than-normal voice calls out, "Morning, hope you're hungry. I made you some breakfast." Sitting in front of me is a big plate of scrambled eggs, greasy bacon, and an ice cold Budweiser. Another big smile as he sees my face turn green and says "Eat up son; we have a long day ahead."

I'll spare you the details, you can probably figure out the rest.

After I cleaned up, Dad put his arm around my shoulders and said "Come along son, let me show you what I was working on the other night." We head out to the police station. You guessed it ... he's a cop.

Photo by: Airman First Class Salma Nebot

At the station, he passes me a folder which has about a dozen or so pictures of a single car accident where the driver was drunk and didn't survive. We didn't have digital cameras back then, but the pictures were clear enough for me to make another run to the bathroom.

Another grin from Dad and off we go, this time to the county sheriff. "Pictures don't do the scene justice son,' he said." I want you to see the driver's car ... take a good, hard look and think about what can happen the next time you get behind the wheel after you've been drinking." To this day, I will never forget the valuable lesson my father taught me that morning. I could just have easily been that guy.

I know someone is reading this and thinking "Cute story but that won't happen to me." For your sake and those whose lives you touch, I hope you're right. When this incident occurred, I wasn't in the military, but more than likely you are. From that angle, let me share with you what you can expect if you decide to "roll the dice."

You're also looking at a Letter of Reprimand and an Unfavorable Information File, and possible Control Roster action that could prevent you from testing, being promoted, getting an assignment and more.

If you are busted on base, expect an Article 15 along with forfeiture of pay and possibly loss of a stripe or two. For anyone that had a line number for promotion, that's probably gone too, along with a referral performance report, possible assignment cancellation, suspended security clearance and other job-impacting repercussions.

Let's take the scenario a little further for some hidden costs you might not know. Assume each person is arrested on base after consuming a six-pack of beer.

*Senior Airman Jones - Article 15, reduced to airman first class. It takes two years to put senior airman back on for a total salary loss of $8,006.*

**Cost per beer: $1,334**

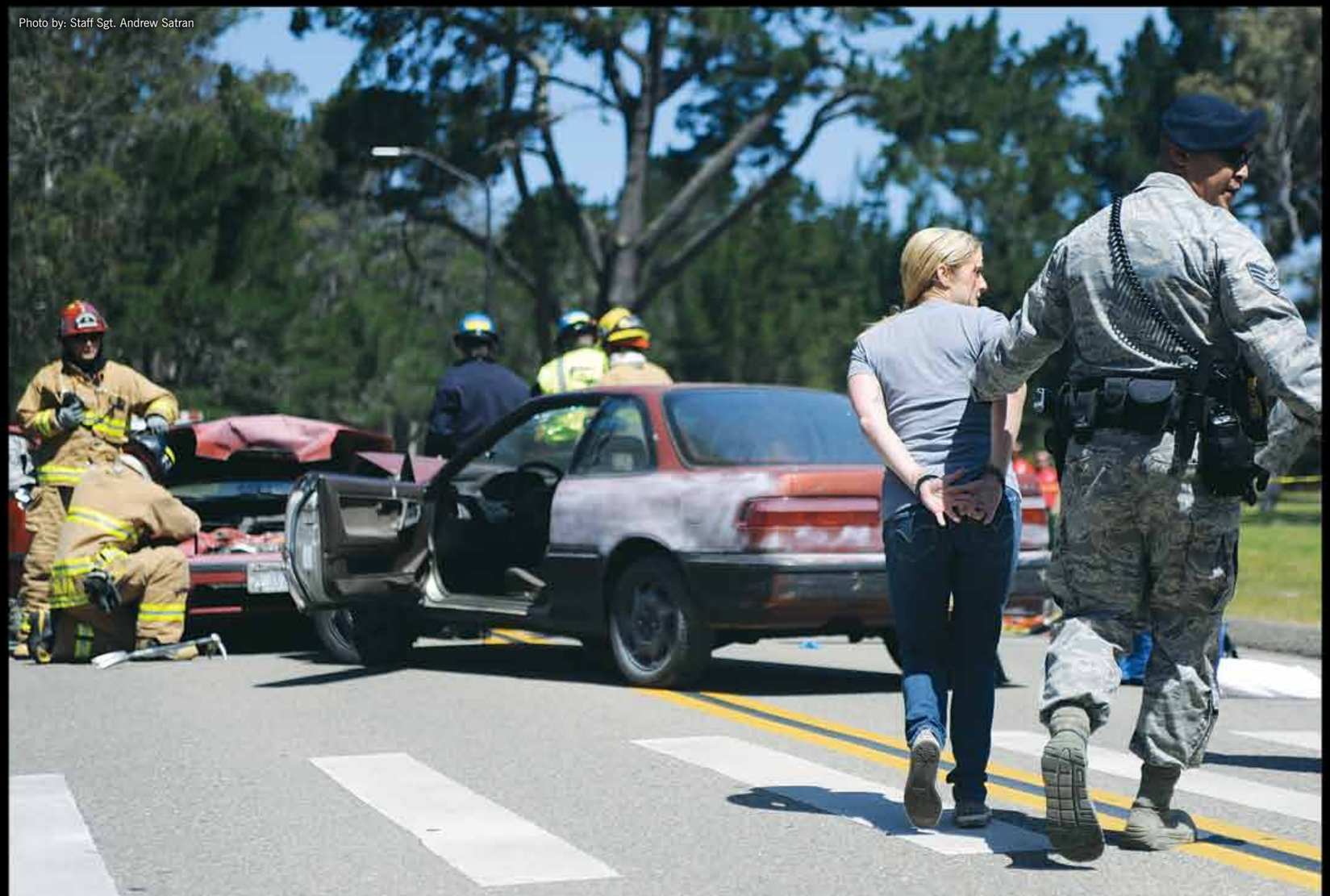
*Tech. Sgt. Smith - Article 15, reduced to staff sergeant. It takes five years to put technical sergeant back on for a total salary loss of $35,358.*

**Cost per beer: $5,893**

*Master Sgt. Thomas - Article 15, reduced to technical sergeant. Retires as a technical sergeant due to high-year tenure; loss of retirement pay over life/30 years is $191,184.*

**Cost per beer: $31,864**

Photo by: Staff Sgt. Andrew Satran



I don't know about you but I can't think of any brand of beer I'd pay $1,300 for.

Did that grab your attention? Because I haven't even talked about the impact this DUI will have on your unit and co-workers. Who has to pick up the slack and do your job when you're behind bars, standing in front of the judge, or doing your community service time? Who picks up the tab when your security clearance has been suspended and you can't perform your primary job? Right again, your co-workers. Since they're busy covering your job, their job suffers, and as a result our mission suffers.

Getting behind the wheel after you've been drinking has a far greater impact than you probably imagined. Not only are you endangering your life and those on the road, you're impacting the lives of your family, friends, and co-workers, plus you're jeopardizing your unit and its mission.

I learned my lesson 30 years ago, have you learned yours?

Photo by: Tech. Sgt. Russell McBride