

Out of *the* Heat and Into *the* Fire

By LCdr. Karl Garcia

Within two weeks of my return from a six-month TAD to CentCom as an individual augment, I became the squadron safety officer. I was integrating myself back into squadron life, getting current in the aircraft, and settling into my new job.

I was a bit apprehensive about taking over as safety officer because I hadn't been to ASO school, nor had I served in the safety department as a junior officer. I felt like a fish out of water, but, at the same time, I welcomed the new challenge. Fully aware of my shortcomings, I paid close attention during my turnover with the outgoing safety officer. I also thoroughly reviewed most of the publications.

During my turnover, I noted the mishap plan needed a few adjustments. I quickly keyed in on the fact that the example messages for OPREP-3 and the mishap-data reports (MDRs) still used the PLADs for ComCarGru versus ComCarStkGru. I made a quick mental note that a few other PLADs likely would need updating.

My ASO and I discussed the mishap binder. We needed to update the formatted-message disk with the proper PLADs. We also had to format it to comply with TurboPrep, because the squadron had shifted format during my TAD period. We made plans to have TurboPrep training for squadron duty officers (SDOs). I gave the task of updating the binder to my ASO and gave him three weeks to complete the project.

Within a week, the squadron had a scare. We received word that a Sailor assigned to an S-3B squadron had died in the barracks overnight, and, that he might be one of ours. Our squadron began an immediate recall, while a fellow department head and I worked through

the decision tree in the mishap binder. We familiarized ourselves with the applicable messages and processes and prepared to generate a SITREP message.

We learned that the Sailor was not in our squadron, but, as a result of our efforts, we realized our mishap binder was not entirely user-friendly or clear when dealing with a Sailor's death. In hindsight, this incident should have served as a wake-up call to take a closer look and immediately update our mishap binder. I gave my recommendations and the task to update the binder to my GSO.

I bore you with these details on updating the squadron mishap binder because, exactly two weeks after taking over the safety department and giving the original guidance to update the mishap binder, the worst thing happened: We had to execute the mishap plan.

I don't recall if I was called to the ready room, or if I walked down to see what was happening. Most of what occurred on Sept. 21, 2005, is a blur. A powerful thunderstorm was rolling through, and I remember someone telling me 704 was down at the end of the runway. The SDO was in contact with base operations and trying to verify if 704 was safe on deck. A tremendous amount of confusion centered on the status of 704, and, at some point, I ended up with the mishap binder in front of me. Aircraft 704 had crashed short of runway 9.

While I still was coming to grips with what was happening, the XO and Ops O quickly organized the efforts. We began marching through the mishap plan and gathered information required for the reports. We got the OPREP-3 Navy Blue phone call to ComLantFlt within the five-minute time limit. By the time the 20 minutes had expired for the OPREP-3 Navy Blue message, the initial aircraft-mishap board (AMB), consist-

ing of the XO, Ops O, AMO and aircraft division officer (previous ASO), were on their way to the crash site. The local news stations already had the story.

The OPREP-3 message gave us our first insight we had more problems with our PLADs than the shift from CCG-CCDG to CSG. Locating the correct PLADs delayed the process and created additional fog and friction. However, with the help of several outstanding junior officers and tremendous support from the admin department, we continued to march through the mishap plan's checklists and procedures. The tasks were divided, and the squadron was a hub of activity, as everyone contributed.

An interesting note is that my ASO was conducting JUMPS validation testing in Pt. Mugu, Calif., leaving the squadron short on mishap expertise and heavily reliant upon the mishap binder.

The CO had been airborne at the time of the mishap and had diverted because of weather to a nearby base. After he was notified by phone of the crash, he made it back to the squadron just in time to chop the MDR (the four-hour message). We had additional delays with the MDR as we sorted through more problems with formats and PLADs. After finally collecting and verifying weather information, the MDR was drafted, but we did not meet the four-hour timeline. We easily would have made the deadline if our PLADs had been correct, and if we had started the MDR simultaneously with the OPREP message, instead of walking down the checklist step-by-step.

The moral of the story is to make sure your mishap binder is completely up to date. Review it to make sure



the information is clear, concise and readily executable. You never know when you will need to execute it. In this case, two weeks was too long from the moment the mishap binder discrepancies were noted to the time it was needed. Things will happen when you are the least prepared and least expect it. In this case, my ASO was unavailable at the time of the mishap, which increased our reliance on a well-maintained mishap plan and binder.

Fortunately, I had familiarized myself with the procedures and identified some of the binder's shortfalls before the mishap. An up-to-date mishap plan would have saved precious time and significantly reduced the confusion already present after our mishap.

Fortune follows the prepared. 

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