



The Safety Sigma

Mission Readiness through Operational Safety

A PRODUCT OF THE U.S. NAVY SCHOOL OF AVIATION SAFETY

FROM THE *NEW* DIRECTOR

As I write this article for my first contribution to the Safety Sigma, I'm already reflecting deeply on the in-depth discussions that I have had with the students in both the Aviation Safety Officer and Aviation Safety Command classrooms since I assumed responsibilities as SAS Director this past May. The topics have ranged from those about the basics of Naval Aviation Safety Management System and how it really works, to discussions about setting the foundations for an enduring culture of operational excellence. But the one topic that always generates the most lively discussion revolves around these closely related themes: "how do we continue to execute our mission safely and effectively with fewer and fewer resources?" and/or "how do we tell our boss that we just can't do a mission or make readiness milestones because we are resource limited?"

Well there is certainly no easy answer here and there are many good strategies available to address these issues; but one significant factor is how the organization will respond to pressure that comes from striving to accomplish the mission. The underlying unit culture --strong or otherwise-- shapes the attitudes and expectations of an organization. At work behind the scenes, embedded in the day-to-day processes, it guides personnel with expectations and norms that tell them "this is how we do things around here". With enough pressurization and insufficient supervision, unit culture can quickly change from a "can-do" culture into a "will do" culture. Now those two terms sound similar, but there is an important subtle difference...

Naval Aviation is renowned for being ready to answer the call and get the job done...it's a positive attribute of our culture. And we take great pride in that...we are truly a "can-do" culture...and that is a good thing. But what happens when "can-do" culture gets pressurized by challenges with aircraft availability, lack of spare parts, currency and proficiency gaps, less than ideal maintenance manning, weather and range issues that create a training and readiness back-log? In all of these cases we usually find ways to compensate and overcome effectively and still get the mission done safely. But sometimes it's easy to lose sight of the forest for the trees. What compromises have we made to meet mission? Do they make sense? Have we really done the right level of Operational Risk Management to mitigate the risk? Or are we building a unit culture where "doing more with less" and "cutting corners" becomes the new normal. In other words, are we

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SUMMER 2015

Special points of interest:

* Hails & Bails

FROM THE *NEW* DIRECTOR (CONT.)

fostering a “will-do” at any cost mentality, tacitly condoning a unit culture where not doing things “by-the-book” becomes the new norm...where deviance from the high standards of Naval Aviation is normalized?

Consider the newly reported maintainer who has never seen his shop Leading Petty Officer using a pre-op card on a piece of Ground Support Equipment, or the nugget aviator who routinely witnesses the DHs, XO or CO taking jets that do not meet Mission Essential Subsystems Matrix (*MESM*) requirements for the mission. Those actions send a message... “this is how we do business around here and the standards do not apply when we have a mission to execute”. One might argue that there are times when getting the X dictates that you take the jet that is not FMC and experience says that you will be able to complete the event safely. But where does that grey line end? Do you want less experienced individuals making similar risk decisions in your organization?

The process of an otherwise solid unit safety culture regressing into a culture where deviations from standards become normalized can be an insidious thing. Following a recent Class A mishap where the squadron had a sterling reputation for getting the mission done and doing it on-time, every time, the 20/20 hindsight provided by the accepted causal factors in the Safety Investigation Report indicated that the unit culture had degraded to the point that deviations from both maintenance and operational standards became routine. The perceived operational pressure to maintain a high-level of mission performance influenced day-to-day processes and procedures to the point that cutting corners became the way of doing business and the unit culture became a “will-do” at any cost culture. Safety Professionals pay attention to the warning signs and use your direct line of communication to the Commanding Officer when you see signs that this situation is developing. We have solid procedures that will keep us safe if we use them. Effective mission performance is the direct result of professional, by-the-book execution and safety is the natural by-product of that effort. A previous article in the Nov-Dec 2013 Approach Magazine that addresses perceived pressure will compliment this discussion.

http://www.public.navy.mil/comnavsafecen/Documents/media/magazines/approach/2013_Nov-Dec.pdf

—CAPT Chris “SanDog” Saindon, USN—Director; Christopher.saindon@navy.mil

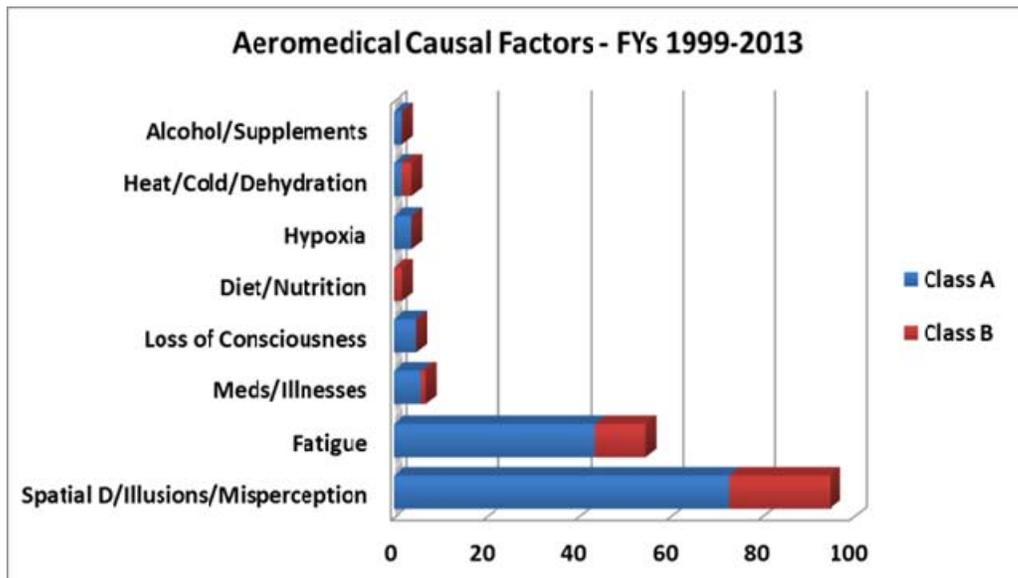


MAN — AEROMEDICAL CAUSAL FACTORS

This will be my last Sigma submission as I will be departing the School of Aviation Safety. I am fairly sure where I am going but I have first-hand experience that PCS orders are not final until you check in to your next command so I will not state here where I expect to be headed. The schoolhouse will have my contact information should you need to reach me in the future. I can say that the School of Aviation Safety is very fortunate to have CAPT Lee Anne Savoia-McHugh, slated as my relief. CAPT Savoia-McHugh is board certified in Family Medicine, has extensive teaching experience and has served at all levels of aviation medicine including time as an operational flight surgeon, and multiple tours at the Naval Aerospace Medical Institute where she currently serves as clinical director. She is an expert on implementing fundamental management processes and is a strong proponent of Safety Management Systems.

The bar chart shown here uses data from the Naval Safety Center and shows how Mishap Aeromedical Causal Factors (Class A and B) rank over a recent period. These factors and their rankings are very similar to more historic data, which shows we still have a ways to go in making necessary changes and improvements in aviation safety. In my prior Sigma submissions, I have covered all of these causal factors in some manner or another with the exception of cold weather operations and illnesses, two topics that I believe are already covered well by our squadron docs. By the time you get to your first operational command, you will have received an introduction to these topics and this knowledge is further

advanced through follow on aeromedical presentations at the command level. As I mentioned above, the ranking of causal factors seen today remain similar to the ranking of causal factors seen in years past making the study, review and reinforcement of these topics critical. The efforts of the aeromedical team though, will be of limited value without you, the ASO doing the same thing on your end. Ensure your aviators are educated and updated on these topics. Do not



allow complacency to set in. Those of you that are squadron ASOs, recognize that you are second only to the squadron flight surgeon when it comes to being the command expert on aeromedical topics and their influence on aviation safety. If you are serving in a group or wing level ASO billet, your efforts are just as important but don't forget you likely have an Aeromedical Safety Officer available on the staff that you can turn to for assistance. These individuals are true subject matter experts on these topics, and I strongly encourage you to use them as well as encouraging the Squadron ASOs in your subordinate commands to do the same.

It has been an enjoyable tour and I wish you all the best in your future flying and careers. Remember, striving to land in as close a condition to the one you took off in (minus expendables) will immensely increase your chances for success. Have fun and stay safe!

—CAPT Jack “Bags” Wyland, USN—Aeromedical Instructor; john.j.wyland@navy.mil

MEDIUM — SAFETY STAND DOWNS

How often have you looked on the command calendar and noticed that “dreaded” SSD that is coming up in the next few weeks? What is it about SSD’s that automatically cause people to lose all control of their bodily functions on the spot? I can look back over my career and count on one hand the number of SSDs that I thought were actually productive and beneficial towards promoting a positive attitude to safety; you know, raising that Safety Awareness Level we discuss throughout the School of Aviation Safety. During our SSD discussion, we bring up the Issue Paper that discusses the survey question, “Our safety standdowns are effective.” It indicated how there is a preponderance of opinions that SSD’s are a waste of time. Our question to you is, “why is that?” What is it that makes or breaks a SSD?

A few of the students in a recent class asked, “Why do we still push SSDs if they are proven to be an ineffective tool at promoting and raising the Safety Awareness Level?” During the SSD discussion in the ASO class, we open up the room to the student’s to provide insights as to what they saw in their SSDs that they thought worked well, as well as what they thought was worthless.

You have artistic license in how you run the SSD! Use your own experiences, or those of your fellow squadronmates to create a relevant and purposeful SSD in the most effective manner you see fit. Let’s try and see if we can help turnaround those perceptions. Here are a few points to consider (Pulled from the interventions section of the Safetyclimatesurveys website:

- Conduct a Safety Standdown focused on unit survey results, mishap/hazard reports, incident reports, recent "near misses," etc. , and utilize audience participation (via large or small group) to further clarify hazards, identify trends, and develop workable solutions. The group's synergy will help to identify previously overlooked factors, and the group-developed interventions will have greater acceptance/compliance.

- Plan Safety Standdowns well in advance to address key issues and heighten awareness. Maintain an updated list of speakers and topics to ensure "short notice" standdowns (e.g., following a mishap or other recent incident) are professional and worthwhile.

- Get Safety Standdowns out of the classroom/auditorium. Supervisor facilitated activities, hands-on training, small group discussions, etc. may be more beneficial.

- Implement a grass roots safety campaign to give junior Marines the opportunity to shape the safety messages vice the usual safety "stand-arounds".

- Seminar based safety day to get at the root of the problems. Reach out to counterparts in similar units for lessons learned and common concerns.

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- Organizations with the longest running safety records are likely to become complacent. Maintain awareness through process reviews, mock drills, training, and sharing of incident/mishap information from other organizations. -Safety training/interventions are not equally effective with all personnel. Tailor safety programs to reach personnel at all levels.

- Review the list/matrix of relevant Issue Papers on the Safetyclimatesurveys website

—CDR Gerald “Pee-Wee” Hermann—*Safety Management Systems Instructor & Associate Director; gerald.hermann@navy.mil*

MACHINE — TURBINE BLADE CREEP

Under normal conditions when a load is applied to a part, the part will deflect or stretch (strain) a certain distance. Assuming we are in the elastic region of the material, the amount of deflection or stretch should remain a relatively constant amount so long as the load does not change. Meaning the amount of stretch is really not time dependent. Creep is a unique condition such that the amount of stretch does change as a function of time. The primary difference is temperature. As mentioned before, if you apply a load to a part it will stretch a certain distance and then remain in that position. If you now heat up the part without changing the load, the part will very slowly continue to stretch permanently even though the load is remaining a constant. This phenomenon is known as creep.

The primary location where our aircraft experience creep is in the hot section of our engines, specifically the turbine blades. These blades are subjected to a very large radial force due to centripetal acceleration. This force elongates or stretches the blades. However due to the elevated temperature these blades will continue to elongate even though the magnitude of the force remains relatively constant while the engine is operating. This elongation or creep growth rate is one of the primary factors that determine when an engine needs to be overhauled. The turbine blades can only stretch so far before they begin to cause problems. Therefore the amount of time between overhauls is a function of how the engine is used. Running an engine at a high temperature setting will increase the creep rate significantly. Many of the modern aircraft engines have some form of digital control system that is used to control the engine and also to log its usage. This is helpful to measure the amount of creep that occurs to the engine turbine blades since the creep rate is a function of both load and temperature.

Most aircraft engines have high power settings that allow for short periods of operating the engine at higher temperatures and RPM. These are to allow for unique situations when more power is temporarily required. During these periods of high power, the digital control system will record them and reduce the amount of remaining time left on the engine due to the increase in creep caused by the higher temperature and load.

Some of these engines are designed such that the digital control system will only reduce the remaining life of the engine once a certain amount of time has elapsed at this higher power setting. It needs to be understood that an increase in creep rate will occur the moment the temperature or load (RPM) has been increased on the component. The operator should not make a routine of operating the engine at the higher power setting and then reducing the power setting just prior to the amount of elapsed time necessary for the digital control system to record it. If this is done, the life of the engine will be reduced yet the digital control system will be unaware of this reduction in life resulting in increased probability of an unexpected engine failure.

—Mr. Rick “Zeus” Wartman—Structures Instructor; rick.wartman@navy.mil



USS WASP, At sea - A power module for the F-35B Lightning II is moved from an MV-22B and onto Wasp, at sea May 22 during Operational Testing 1. OT-1 evaluates the full spectrum of F-35B measures of suitability & effectiveness, and assesses the integration of the aircraft into the

MISHAPS — THE IMPORTANCE OF MATERIAL FACTOR REPORTING

Historically Human Factors are determined to be causal factors in most Naval Aviation mishaps but Material Factors are also identified to be causal factors. Human Factors are often causal in Material Factors but the reporting of specific Material Factors is of great importance due to the complexity involved in the redesign and/or allocation of new equipment to eliminate material hazards.

OPNAV 3750.6 (Series) Chapter 7 describes the use and importance of Material Factor reporting and the Naval Safety Center reported that 25% in FY13 and 26% in FY14 of Naval Aviation mishaps contained Material Factors. We cannot ignore factors that are determined to be causal in a quarter of Naval Aviation mishaps, especially considering the accounting and funding challenges associated with aircraft/UAS redesign and acquisition. Accurate and timely reporting of material hazards is imperative and there are specific processes designed to eliminate and/or mitigate the risks associated with these material hazards.

The percentages listed above do not encompass Hazard Reports (HAZREPs) but HAZREPs are also of extreme importance in the process of rectifying material defects that could potentially lead to mishaps. Naval Air Systems Command (NAVAIRSYSCOM) tracks material factors in order to allocate funds for corrective action and relies heavily on reported events to calculate risk indices for hazards. NAVAIRSYSCOM program management is continually apprised of risks associated with fleet submitted HAZREPs and uses this information to allocate limited funding in order to eliminate and/or mitigate these risks.

The System Safety Working Group (SSWG) is another tool used by NAVAIRSYSCOM to discuss reported material hazards as well as inform the fleet of critical safety issues related to these hazards. Reported hazards are discussed and risk elimination and/or mitigation strategies are passed to fleet representatives. The 2015 FA-18 E/F and EA-18G SSWG message states, "Fleet representation is critical to working group effectiveness." The valuable information discussed and subsequently summarized in the SSWG Annual Report is an excellent resource to Naval Aviation in the identification of material hazards as well as the identification of strategies that can be used to eliminate mishaps caused by material hazards.

Ultimately everyone involved in Naval Aviation is responsible for the accurate reporting of material hazards in order to aid NAVAIRSYSCOM in their efforts to eliminate material hazards and increase overall Navy and Marine Corps operational readiness.

—LCDR Richard "OB" Winstead—Reporting Instructor; richard.winstead@navy.mil



EA-18G at sea - An EA-18G from VAQ-141 Conducts carrier-based flight operations.

CRM — YOU SPOKE, WE LISTENED

In January 2015, the Naval School of Aviation Safety, Crew Resource Management department modified the curriculum of the CRMI Course in order to provide a better product to the Fleet. During the Operational Readiness Review (ORR) in 2014, we reviewed over 2 years of course critiques. The ORR revealed one major trend; the students felt the CRM course was heavily definition based. The majority of the students felt more time should be focused on the tools required to teach the 7 Critical Skills of CRM in the fleet rather than an in-depth review. After taking a step back and reviewing the syllabus, the instructors agreed with the critiques and made some changes.

The seven skill review on Day 1 has been modified from a 45 minute review per skill, to a 15 minute review per skill. As instructors, we recognized that the aviators being sent to the CRMI course already possess a solid grasp of the 7 skills. Therefore, we quickly re-baseline all the students on the CNAF definitions and review the barriers to CRM that commonly occur during breakdowns. A case study is presented during the second segment of the 7 Skills review. They are comprised of a recent mishap pertaining to the skills being discussed. After the synopsis of the MISHAP, the students are asked questions pertaining to the breakdown of CRM in the case study and how the breakdowns possibly contributed to the MISHAP. During the class, the CRMI students are given the opportunity to read through the SIRs and HAZREPs. This facilitates a discussion and allows the student to draw out the instances when poor CRM directly contributed to a MISHAP or when good CRM averted some type of incident.

The case studies will be updated or replaced annually. Currently the course covers the following mishaps: Communication and Assertiveness, HMMH-466 June 2014 Class A fuel starvation; Leadership, Mission Analysis, and Adaptability/Flexibility, HMLA-167 March 2013 Class A CFIT following approach; Situational Awareness and Decision Making, VAQ-129 March 2013 Class A CFIT. The presentation of the CRM in this manner tests the students' knowledge of the skills being taught. It also, provides them with examples of how to present CRM training back at their parent commands.

—LCDR Colin “Shoe” Warfield—CRM Instructor; colin.warfield@navy.mil



The SAS CRM team, posing with the Naval Safety Center CMC, (SW/AW) Paul A. Kingsbury who was in town to audit a CRMI course

CRM — HOW TO GET A CRMI CLASS QUOTA

As of 27 FEB 2015, we implemented a new CRM quota policy. All CRMI Pensacola class quotas requests will come through the T/M/S Program Managers, not from individuals or squadron Unit Level Managers.

Since the release of CNAF 1542.7A we have received a higher volume of quota requests for the CRMI course in Pensacola. Normally we are able to honor all requests received. In an effort to support fleet activities, we have overbooked all classes since November 2014. Our operating instruction dictates we have a standard class quota of 18 students. The past 4 Pensacola classes have had between 20 and 23 students with 6 - 7 members on standby. Since FY12, we have educated 1,128 CRMIs. The breakdown: FY12: 233; FY13: 343; FY14: 395; FY15 to date: 157 (552 projected). Despite conducting an average of 10 Mobile Training Teams (MTTs) per year and the over bookings of both the Pensacola and MTT classes, we continue to receive calls from Program Managers (PMs) stating that there are not enough CRMIs in their perspective communities.

Two possible causal factors for the low numbers of T/M/S CRMIs in operational commands:

(1) CRMI seats are being filled by members who have less than 6 to 8 months remaining in the squadrons; these newly minted T/M/S CRMIs are transferring to different T/M/S squadrons shortly after designation (HT/VT or Disassociated Sea tours/etc..). The PMs would have higher T/M/S CRMI yields if the majority of perspective CRMIs had 12-18 months left on station. Plus the commands would get more for their money and drastically reduce gapped billets. This fact would be negated if the CRMI student is transferring to a different squadron with the same T/M/S.

(2) In the recent past, members would reserve their own seats for the Pensacola class. Then not show up and forget to send us a cancellation email. Typically, we have 6-7 members on standby. If cancelled, we can offer these valuable seats to members on the standby list and improve the CRMI numbers in the fleet. This new policy should alleviate the CRMI shortcomings currently being experienced throughout the fleet. Currently, classes are filling up three months prior to the convene date. This requires commands to be diligent tracking their CRMI quals and getting requests to the PM early in order to prevent billet gaps. Also, about 10% of our Pensacola students are recent ASO graduates. We have facilitated this by offering the CRMI class between ASO sessions. If the parent commands desire their recent ASO to earn a CRMI certificate, please reserve their seats at least 4 months prior to class commencement. Without PM endorsement we will not be able to honor their individual requests. We recommend when they are booked for ASO class that the PM send us a CRMI seat request. Please keep in mind that space is limited; and that the ASO and CRMI courses are two separate programs. Below are our upcoming class dates:

CRMI 15-09 15 JUN 2015 – 18 JUN 2015	CRMI 15-10 13 JUL 2015 – 16 JUL 2015
CRMI 15-11 24 AUG 2015 – 27 AUG 2015	CRMI 15-12 14 SEP 2015 – 17 SEP 2015
CRMI 16-01 05 OCT 2015 – 08 OCT 2015	CRMI 16-02 16 NOV 2015 – 19 NOV 2015
CRMI 16-03 07 DEC 2015 – 10 DEC 2015	CRMI 16-04 11 JAN 2016 – 14 JAN 2016
CRMI 16-05 08 FEB 2016 – 11 FEB 2016	CRMI 16-06 21 MAR 2016 – 24 MAR 2016
CRMI 16-07 04 APR 2016 – 07 APR 2016	CRMI 16-08 02 MAY 2016 – 05 MAY 2016
CRMI 16-09 13 JUN 2016 – 16 JUN 2016	CRMI 16-10 11 JUL 2016 – 14 JUL 2016
CRMI 16-11 22 AUG 2016 – 25 AUG 2016	CRMI 16-12 12 SEP 2016 – 15 SEP 2016

To reserve a seat Contact the CRM Quota Manger, LCDR Warfield, via email; colin.warfield@navy.mil

—LCDR Al “Judge Red” Toney—CRM Director; alvin.d.toney@navy.mil

SEMPER PARATUS — CLOSING THOUGHTS

I am about to close out 3 rewarding years as the first USCG officer billeted to SAS as a payback tour for CG-funded safety graduate school. LCDR Vincent Jansen has been identified as my relief and he will arrive in January of 2016 to propel the USCG presence and influence at SAS even further. As a minority member of the SAS staff with prior experience as a Marine aviator and significant familiarity with the Navy, I want to pass on some closing thoughts and observations:

- 1) USCG Flight Safety Officers (ASO equivalent) apply for their billets via our detailers and as of summer of 2015 assignments will be made using a full-blown headquarters board selection process. Our new FSOs beat out many other qualified applicants for their positions, and when they arrive at SAS they are motivated. Our service sweetens the deal as the FSO billet is most certainly a stepping stone to one of the coveted safety grad school billets. Our FSO billets are highly sought-after and respected and the future of this specialty looks great.
- 2) Healthy HAZREP/Class D mishap reporting (i.e., the events that are easier to ignore and not report on) correlates with lower Class A+B mishap rates in a military service. I am convinced that no service is reporting *everything* that needs to be reported. We all need to realize this and be in constant pursuit of reporting *everything* which is reportable per our policies. The smallest HAZREP or Class D report tells a story and may support a trend or have some other intangible benefit to someone. Commands that report little or no HAZREPs in a year are like apathetic fathers who don't care if their kids have the opportunity to benefit from hearing about their mistakes. When the data shakes out, no one really believes that minimal HAZREP/Class D reporting is evidence of an error-free fiscal year. Squadrons, air stations, and fathers all commit errors and violations within any 12-month period. The ones with guts, who are generally interested in making things better, analyze them and write reports on them.
- 3) We have often discussed how hard it is to measure the effectiveness of a safety program, or an SMS. We are in an age where everyone wants to see the "metrics." Though there are many possible, what is the best-known safety "metric" in most military services? Sadly, it's the fiscal year Class A mishap rate. We talk of being proactive, yet our best-known metric is the one that measures how many Class A flight mishaps occurred per 100,000 flight hours—reactive data. I don't think other winning programs do this. Do you think Coach K., Duke basketball head coach, discusses the rate of games he loses with anybody? Everything I've read on him suggests he doesn't. Instead, he maintains an amazing culture and looks for small things to correct, and expect those small things to be brought to his attention at a sufficient rate. This parallels an ASAP program and a solid reporting culture in general. When you hear him speak prior to a game or tournament, he talks as if he has a genuine understanding of his team's strengths and weaknesses. DoD HFACS data is an immense catalog of our services' strengths and weaknesses. Our best-known metrics should be predictive, and the DoD HFACS data is a great place to start.

I am honored to be able to continue to serve in safety in my next billet at Coast Guard Aviation Training Center Mobile. Please reach out if there is anything you ever need.

—LCDR Jim Bates, USCG—Coast Guard Instructor; james.a.bates@uscg.mil

Coast Guard Air Station Clearwater - An MH-60 Jayhawk helicopter crew from assists survivors out of the Jayhawk at the air station, Monday, May 18, 2015. The crew rescued the six adults and two children after their boat began to take on water 33 miles west of Anna Maria Island, Fla. USCG photo, released.

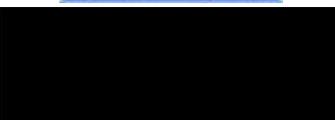


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"Doc" Bank Memorial Award

The *Milt "Doc" Bank Memorial Distinction*, recognizes the student or students in each graduating ASO class who best exemplify the characteristics of the late, great Milt "Doc" Bank, PhD: motivation, intelligence, imagination and aptitude to be a potential future ASO Instructor. The recipient of this award for ASO Class 15-6, the winner was LT Maile Richert, USN; for ASO Class 15-7 the winner was LCDR Michael Felber, USN.

Also, if you would like to be removed from future emails, please email LCDR Winstead (info above) with name and approximate dates of your class attendance.



The Safety Sigma is published quarterly by the Naval School of Aviation Safety located at NAS Pensacola, Florida. If you have a question for the staff, or are interested in attending Aviation Safety Officer, Aviation Safety Command, or Crew Resource Management Instructor training, please visit our website at <http://www.public.navy.mil/navsafecen/Pages/aviation/SAS/index.aspx> or call (850) 452-3181. **If you would like to submit** a short article for publication, please contact LCDR Richard "O.B." Winstead at richard.winstead@navy.mil.

SPECIAL POINTS OF INTEREST

HAILS AND BAILS

The SAS staff lost four long-time instructors this summer:

CAPT Jack "Bags" Wyland, USN
LtCol Stephen "Bender" Dickerson, USMC
LCDR Phil "Dr. Phil" Fatolitis, USN
LT Jim "Pugsly" Bates, USCG

Thanks to all for your outstanding support of SAS and our fleet safety cultures at large! We also welcome:

CAPT Chris "SanDog" Saindon, USN (Director)
CAPT Lee Ann "Xena" Savoia McHugh, USN (AeroMed)
LCDR Julio "KG" Ledesma, USN (SMS)
LCDR Gregory "Debbie" Gibson, USN (Human Factors)
LCDR Christopher "Coop" Cooper, USN (CRM)
Maj Viet "Mahu" Tran, USMC (Investigations)
Capt Jeff "Fruit Bat" Menne, USMC (RW Aero)

SAS FACEBOOK PAGE

The Official SAS Facebook Page can now be accessed at

www.facebook.com/navsafetyschool

Be sure to "Like" us in order to immediately receive important information and articles relative to your job, your community, and the School of Aviation Safety. Your level of involvement can make this a truly worthwhile online community of aviation safety professionals. This is soon to become the primary way of announcing new issues of the Safety Sigma, so please join our Page.

