

# What Happens When the Brief Gets Too Brief



## Identify Hazards

*Inadequate planning for the mission  
Poor visibility  
Difficult communications  
Low on fuel  
Non-standard procedures  
Pressure to complete a flight*

Every crew brief covers ORM, but the ORM part often lacks depth. Mission commanders and flight leads simply ask if everyone has had enough crew rest. ORM is much more than that. On one flight in the skies over Macedonia, the crew had gotten plenty of sleep, but still came a split-second from disaster.

I was ECMO 1 in an EA-6B during a night-strike mission over southern Kosovo. After the strike, we headed toward our tanker. The **communications** with AWACs were **unusually weak and full of static**. A **layer of broken clouds** was just below the tanker altitude. Without air-to-air radar or night-vision devices, finding the tanker was next to impossible. With **our fuel getting close to bingo**, we finally found the tanker and commenced the join-up on the left, which is the standard side for the Navy, but not standard for the Air Force.

We **hadn't briefed which side of the tanker** we would join on—during the brief, mission planning had overshadowed that level of detail. Once joined, we realized that two British Tornados were already on the tanker, one taking fuel and the other on the right side. After they finished, I saw Dash 2 disconnect and **apparently clear off below us**. As we slid back, anticipating getting in the basket, a bright flash filled our cockpit, accompanied by severe buffet. The Tornados had tapped burner right in front of us, instead of exiting down and aft. They had turned off their lights and had moved left into us. **My pilot dumped the nose and avoided them**. We climbed back to the tanker, got our gas, covered another strike, and returned to Aviano.

Once on deck, I told the operations officer what had happened. **Tanking briefs started getting a lot more attention**. In the 45 days we were over the skies of Bosnia, this near-midair was **one of the most hazardous flight events I experienced**. Our crew had wanted to complete the air refueling, avoid a bingo divert into an unfamiliar airfield, and support the last of the night strikes. The internal drive to complete a mission, whether combat or peacetime, can cloud aircrew's judgment. ORM easily could have lessened the severity of the problem or broken the chain of events leading to it. ■

*by Capt. David Levenson, USAF*

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## Make Risk Decisions

*This aircrew worked through several problems, deciding to accept the risk as they went along. In retrospect, it was both unacceptable and avoidable to show up at the tanker with a bunch of other aircraft following different procedures for joining up and departing.*



## Assess Hazards

*Since the hazard of non-standard procedures wasn't covered in the brief, they didn't have a chance to do this step. The resulting near-midair dramatically answers the question, "What could happen as a result of this hazard?"*



## Supervise

*You can't see if controls are working when you don't have any in place. All you can do is recognize impending disaster and react.*



## Implement Controls

*There was no chance to put in place a control over the hazard of non-standard procedures. The control that was needed became crystal clear in retrospect.*