

THE ATTERBURY ATTITUDE

VOLUME 1

22 JUL 2012

CIVIL AIR PATROL'S
NATIONAL
EMERGENCY
SERVICES
ACADEMY
WELCOMES
YOU!



EDITED BY ONE CRAZY GHOST!



WELCOME TO "MUD-BERRY"



SOLDIERS TRAINING AT CAMP ATTERBURY DURING WW II
<http://www.angelfire.com/in2/joworld/WWII/atterbury2.jpg>

This was the "affectionate" nickname for Camp Atterbury seventy years ago. Hard to believe as one observes the seemingly bone-dry, dusty landscape and experiences the stifling heat and humidity. Let's go back in time to an era when radio was king, swing bands were in vogue, and the United States entered World War II.

Shortly after Japan's surprise attack on Pearl Harbor on December 7, 1941, the U.S. Army announced that it needed to build a military training facility in South Central Indiana. Over forty thousand acres of land, much of it rich farmland that had been owned by families for generations, was turned over to the federal government. The farmers were financially compensated, but for many the loss of land was involuntary.

The military base would be named after Brigadier General William Wallace Atterbury, an Indiana-born railroad transportation expert during World War I. By April 1942, approximately 15,000 workers were contracted to build housing and facilities for 30,000 troops. It rained almost incessantly over the next several months, resulting in muddy terrain that interfered with the movement of vehicles and personnel. The laborers dubbed the base "Mud-Berry," and this handle would stick once the first soldiers arrived in April 1942.¹

Camp Atterbury was a booming place during World War II, processing over 275,000 troops. Aside from offices, barracks, and training facilities, there were gymnasiums, places of worship, restaurants, and movie theaters on base. The camp had its own bus line as well as a railway system.

Wakeman General Hospital served as a convalescent center for wounded soldiers during the war. It had 9,000 beds! Specializing in plastic surgery, neurology, and artificial eye prostheses. "Wakeman was one of the best-equipped among the forty-three specialized general hospitals in the United States ..."² In February 1945 there were 1,860 military personnel and 600 civilians working at Wakeman General Hospital.³ The hospital was deactivated on December 31, 1946, only to be reopened



Camp Atterbury's Wakeman General Hospital, circa 1951

www.71stos.com/buildingatterburyfield.html

in August 1950 due to the Korean Conflict. Its doors would close permanently in March 1954.

Atterbury Job Corps, just west of Camp Atterbury's main security gate on Hospital Road, now occupies what was once a small portion of Wakeman General Hospital.

During the latter half of World War II, there were approximately fifteen thousand German and Italian prisoners of war on Camp Atterbury. Many earned money by working on local farms and canneries. The prisoners took the initiative to set up sports clubs, bands, and other activities of interest while in the internment camp.

The Chapel in the Meadow, now restored to its original beauty, sits in a quiet meadow off Hospital Road. This 12 x 18 foot sanctuary was constructed by Italian artisans during the war. Using dyes made from plants and human blood, frescoes were painted on three walls and the ceiling. On one side, the chapel is open to the elements, allowing more celebrants to face the altar during Roman Catholic Masses.

Camp Atterbury was deactivated in December 1946, then reactivated during the Korean Conflict. It has gone through periods of disuse since that time, but is now a vibrant, dynamic military training center. As you walk or drive about Camp Atterbury Joint Maneuver Training Center, try to visualize over 44,000 troops on site preparing for overseas combat. Imagine walking into a hospital with 6,000 patients.

History is always fascinating. It provides a different perspective, a new viewpoint that enriches our understanding of the present. Seventy years ago, Camp Atterbury's primary mission was to prepare soldiers for combat. Today's counterpart, the Joint Maneuver Training Center, utilizes new weapons and new technology to accomplish that same undertaking.



Chapel in the Meadow



Ceiling Fresco: Dove of Peace⁴

¹ West, James D. *The History of Camp Atterbury: compiled by Col Clifford M. Brown.* December 17, 2006
www.indianamilitary.org/Camp%20Atterbury/History/history_of_camp_atterbury.htm

² West, James D. *Indiana in World War II: The Hoosier Training Ground. Wakeman Hospital.* 2007.
www.indianamilitary.org/WakemanHospital/HoosierTrainingGround/HoosierTrainingGround.htm

³ Ibid.

⁴ http://members.tripod.com/camp_atterbury/POW/ChapelCeiling98.jpg

FROM NESAs SAFETY OFFICER, LT COL BOB TAYLOR



Welcome to Camp Atterbury! In order to insure your safety & well-being, we ask that you follow the policies & procedures outlined below. All participants will have a safety briefing each morning based on the day's activities.



VEHICLE SAFETY:

Seat belts will be worn at all times.

Drivers are prohibited from using cell & speaker phones while vehicles are in motion.

Blue tooth devices are allowed.

Be aware of one way streets. They're posted.

Headlights on from dusk to dawn. Headlights on in inclement weather as well.

Maintain the posted speed limit. It is usually 25 mph on main access roads & 10 mph on side roads & when entering & exiting the base. The speed limit is 10 mph when approaching pedestrians, and it is 5 mph when passing running or marching troops.

PARKING IN CANTONMENT AREA:

Vehicles will be backed into designated parking spaces.

Parking restrictions will be posted as needed.

Do not load & unload pedestrians or belongings while in the lane of traffic (with the exclusion of military buses).

PEDESTRIAN SAFETY:

Use sidewalks when possible.

When in formation, post road guards at intersections.

Reflective vests/belts are required when walking on base from 1800 to 0600 and in inclement weather (with the exception of NESAs cantonment area).

WEATHER SAFETY: *SAFETY & MEDICAL WILL MONITOR WEATHER CONDITIONS AT ALL TIMES!*

TORNADO SAFETY

In the event of a tornado warning, if in the barracks, go to the bathroom.

If in a trailer, leave the trailer. Seek shelter in a solid structure. If that is not available, go into a ditch.

If in the mess hall or in the field, follow the directions of your supervisor.

If in a vehicle, get to a secure building. If unable to do this, get out of the car & go into a ditch.

LIGHTENING SAFETY

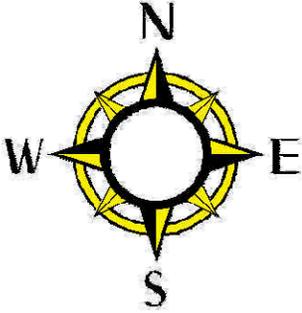
If in a car, stay inside the car with all body parts inside. (Convertibles are NOT safe in a lightening storm, however).

If in a field, go to the tree line but avoid the tallest trees. Crouch down on the balls of your feet.

Avoid metal sheds or bleachers.

Follow the instructions of your supervisor.

GROUND SEARCH & RESCUE SCHOOL (GSAR) SAFETY



- ❖ Water will be carried at all times in canteens or Camelbaks.
- ❖ Horseplay: **KNOCK IT OFF!**
- ❖ Knives & Gerber/Leatherman tools are to be used correctly & only as needed.
- ❖ Orange reflective safety vests will be worn at all times in the field.
- ❖ ORD (Ordinance): **DO NOT PICK UP** any brass seen in the fields. If you are concerned, notify your supervisor and he/she will in turn notify the Safety Officer.

U.S. ARMY HYDRATION GUIDELINES

WEATHER CONDITION	QUARTS WATER/HOUR	MINUTES WORK/REST PER HR
White Flag: 78-81.9 deg F	At least ½ quart	Continuously
Green Flag: 82 -84.9 deg F	At least ½ quart	50/10
Yellow Flag: 85-87.9 deg F	At least 1 quart	45/15
Red Flag: 88-89.9 deg F	At least 1 and ½ quarts	30/30
Black Flag: 90 deg F & up	At least 2 quarts	20/40

Kolka, Margaret A., et al. *Current U.S. Military Fluid Replacement Guidelines*.
<ftp://ftp.rta.nato.int/PubFullText/RTO/MP/RTO-MP-HFM-086/MP-HFM-086-06.pdf>

A TALE OF TWO TEAMS AKA THE WEAK VERSUS THE STRONG



While the Indiana Colts are being spoon fed, preparing for their climate-controlled, artificially-sodded stadium, the New England Patriots are training at the Arctic Circle in preparation for REAL football in REAL weather on actual grass containing chlorophyll!





INTRODUCING CADET 2d LT NAOMI SHEA

Naomi was born in Tacoma, Washington on April 15, 1996. She is the youngest of six children, preceded by Daniel (25), Jonathan (23), Rebekah (19), Sarah (18), and Benjamin (17). The family moved to San Diego when she was eleven years old, then to the Birmingham, Alabama suburbs in October 2010.

Entering her sophomore year at Chelsea High School this fall, Naomi is a member of the Math Club and Show Choir. She particularly enjoys history and science and is a member of the National Beta Club. This organization recognizes high academic achievement, character, and leadership.

Her hobbies include roller blading, wake boarding, and swimming. She loves to read, and enjoys eating Nutella.™ Her favorite food, however, is lasagna. Did I mention that Naomi plays the guitar, and has been writing lyrics since the age of seven? Country music is her preferred musical genre. This cadet's favorite musicians include The Band Perry

and country artist Blake Shelton.

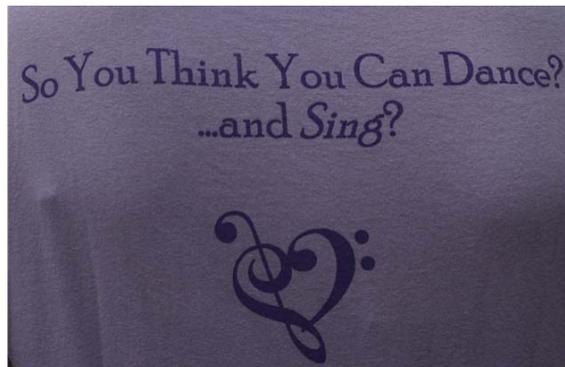
Naomi joined San Diego's 144th Cadet Squadron, Civil Air Patrol, in June 2008 and has been a member of Birmingham, Alabama's 117th Air National Guard Squadron since October 2010. Her staff duties have included Flight Sergeant and Flight Commander. On July 10, 2012, Naomi earned her General Billy Mitchell Award.

Volunteer service comes naturally to this cadet. She has logged eighty volunteer hours at her local YMCA, helping care for young children. She was on staff at Alabama Wing's Emergency Services School from October 2011 through April 2012. Incident Command Staff School Administrative Office and Instructor Captain Jan Hulseley has this to say about Naomi:

"She arrives in advance of most participants at NESAs. She works for all of us, doing anything she is asked to do. If she sees that something needs to get done, she steps up to the plate and gets it done. Most impressive, she has a wonderful, very positive attitude."

Naomi will serve as a Team Leader at Basic Ground Search and Rescue (Basic GSAR) School during NESAs's 2012 Session II. Her stepfather, Lt Col Larry Mangum, is Lead Instructor for Incident Command Staff School.

**NAOMI'S
SHOW
CHOIR
TEE
SHIRT**



A FAIRY TALE IN PROGRESS ...



"A long time ago, there was a pond named Froggy Bottoms Pond in Washington State. I would go there with two neighbor boys, and we would catch bunches of frogs. We'd put them in buckets and carry them home." Her father would counsel her:

"No matter how many frogs you kiss, they won't turn into princes."

Naomi Shea did try to kiss a frog once, just to see what would happen. "It just ribbited back at me!"

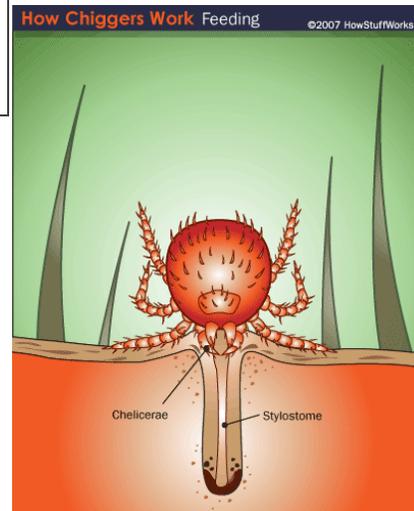
BEWARE OF THIS LITTLE CUTIE ... THE CHIGGER ... THE JIGGER ... THE RED BUG!

This tiny six-legged critter can move fast ...to places you'd rather not share with anyone else. Let me tell you more about *Trombicula alfreddugesi*. These no "see-ums" don't burrow under the skin, contrary to popular belief. You might say they like frappes. Not strawberry or chocolate, mind you, but rather liquefied skin cells. Yummy! They even use a special straw! You see, this little bugger attaches its mouth-parts onto a skin pore or hair follicle. It then secretes a digestive enzyme to disintegrate skin cells. After sucking up the tasty brew, the chubby cutie drops off to lay in the soil until autumn.

Chiggers like snakes, toads, rodents, birds, livestock, and yes, us humanoids. Let's just say that they are a non-discriminatory parasite! On humans, they like going under socks, around ankles, behind knees, under arms, beneath elastic underwear bands, and **literally under the belt!** The result is a red welt that itches **ferociously!** The problem is that once you itch, it is too late. The chigger has already fallen off, remember?

So, how can you avoid an attack by this *mitey* pesky pest? First off, steer clear of weeds and thick vegetation and avoid sitting on the grass. This might be an issue for all of you ground-pounders! Apply DEET to socks, pant cuffs, ankles, legs, around your waist, and to your lower sleeves and wrists. It takes several hours for the critter to latch on and start frapping your skin cells, so taking a hot shower or bath might help wash the cutie away.

As for the itch, nail polish won't help. The chigger has already fallen off. You can apply Afterbite™ or any over-the-counter anti-itch ointment. Application of an antibiotic cream may help to prevent secondary infection.



This individual, one "Johnny," is said to be participating in GSAR this week. Wearing the logo of a cheatin' team near a member of Red Sox Nation! This person deserves jail!



LYME DISEASE FROM A PEDIATRICIAN'S PERSPECTIVE

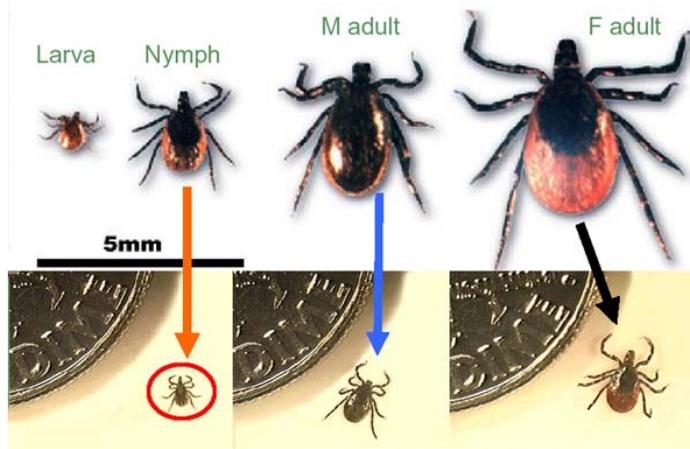
By LouAnn Maffei-Iwuc, Lt Col, CAP
Medical Officer
Massachusetts Wing, Civil Air Patrol

A fourteen year old female was seen in a Cape Cod hospital emergency room in August 2010 with a rash on her abdomen. The parents thought she had Lyme disease, but the attending physician disagreed. She was treated with a ten day course of cephalexin (versus what would have been a 21 day course of another antibiotic). This same adolescent was seen in February 2011 at our urgent care site with left elbow swelling. There was no history of injury, no history of fever, and no redness or increased warmth of the joint. X rays were normal. She wore a sling for several days and the swelling went away. One month later, she arrived at my office. Her left knee was markedly swollen. There was no known injury, no fever, no redness or increased warmth. Labs were drawn, her joint was tapped by an orthopedic associate, and, as suspected, she had Lyme arthritis. She was placed on a four week course of oral antibiotics.

A four year old male came into the office during the summer of 2009 with a four day history of high fever, headache, and lethargy. On exam, he did not have an ear or throat infection, nor did he have nasal congestion or stiff neck. There was no history of rash or known tick bite. He appeared ill. Labs are drawn, and he was referred to the emergency room for a spinal tap. He was admitted to the hospital, subsequently diagnosed with Lyme meningitis and was discharged home several days later with a PIC (percutaneous intravenous catheter) line, allowing a visiting nurse to administer daily antibiotics to complete a six week course.

A seventeen year old female left her home in St. John, U.S. Virgin Islands to visit friends in Rhode Island for one week in June. She returned home and one month later developed migraine headaches and a sore neck. There was no known history of tick bite or rash. Pain medication was prescribed by a local island clinic. Still not feeling well one week later, she returned to the clinic and a blood count was drawn. It was abnormal. Upon her request, I called the clinic and asked them to run a series of tests, including Lyme. The clinic did not have the capability to run Lyme titers. The headaches subsided, but she developed intermittent eye inflammation. Several weeks later, she flew to Boston accompanied by her mother and grandmother. While driving to UMass Medical Center in Worcester, it was evident that her eyes were notably inflamed. After obtaining a thorough history and exam, the pediatric infectious disease specialist ordered laboratory studies and immediately referred her to a corneal specialist. "If she had come one week later, I don't know if we could have saved her vision," was the ophthalmologist's quote. She was diagnosed with Lyme meningitis and Lyme infection of her corneae. The Student Health Center at her chosen university needed to learn new skills in order to provide care for this newly matriculated student, as she required a six week course of daily intravenous antibiotics via a PIC line.

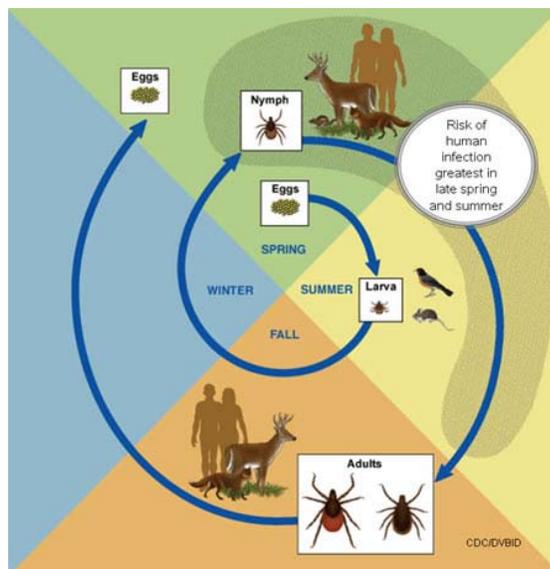
Borrelia burgdorferi, a corkscrew-shaped (spirocete) bacterium, is the culprit, folks! It is the causative agent for Lyme disease. The principle reservoir of infection is *Peromyscus leucopus*, commonly known as the white-footed mouse. The primary vector, or carrier, in New England is a nasty little tick called *Ixodes dammini*, the deer tick.



Representation of the deer tick at various stages of growth by CapeK9Cardio™¹

The lifespan of a deer tick averages two years. Adult ticks lay eggs on the ground in the spring. The eggs hatch as larvae during the summer, and the larvae feed on mice, other small mammals, and birds from summer until early autumn. If the ingested blood meal is infected with *Borrelia burgodoferi*, the tiny tick is infected for life. There is a period of dormancy when the larvae grow into nymphs. Searching for blood meals in order to grow into adults, the still tiny nymphs feast primarily on rodents. Yet nymphs are the most common stage of tick to bite dogs, cats, and humans as well. The peak season for humans and their pets to get infected with Lyme disease is May, June, and July, when the nymphs are most active.

So, where does “deer” come into the picture? The adult ticks have not vanished, folks! They feed on large mammals such as deer (and, sigh, us as well!) and are most prevalent in the spring and autumn. The deer do not become infected by *Borrelia burgodoferi*. They just serve up yummy blood for the deer tick, sustaining the tick population and transporting these lovely critters throughout the woods and fields. It is possible to get infected with Lyme disease during the winter, as adult deer ticks will emerge in search of blood meals if the temperature rises above freezing. Below is a drawing of the life cycle of the deer tick, courtesy of the United States Centers for Disease Control (CDC):



Life Cycle of Blacklegged Ticks²



Lyme disease is the number one arthropod-borne illness in the United States.³ The majority of cases in the United States occur in New York, Massachusetts, Connecticut, Rhode Island, and New Jersey.⁴ There are cases of Lyme disease in other parts of the nation, transmitted by *Ixodes scapularis* in the South and *Ixodes pacificus* along the Pacific coast. The actual percentage of deer ticks infected by *Borrelia burgdorferi* ranges from 2 to 90% and varies from species to species, from state to state and even from county to county.⁵

"Studies have shown that an infected tick normally cannot begin transmitting the spirochete [*Borrelia burgdorferi*] until it has been attached to its host about 36-48 hours..."⁶ Seventy to eighty percent of infected humans will develop a circular rash at the site of the bite within three to thirty days of being bitten. The erythema migrans rash can be a solid area of redness (erythema), can have a bull's eye appearance, or can look like a bruise in darker-skinned individuals. If untreated, over the next several days to weeks the area of rash will expand, reaching a diameter of up to twelve inches in some cases.⁷ In this early localized stage, the individual may also have achy joints, chills, fever, and/or fatigue. The photo above is courtesy of the U.S. CDC.⁸

In early disseminated Lyme disease, other areas of rash may develop away from the initial tick bite site. The individual may have one or several of a constellation of symptoms: fever, fatigue, swollen glands, headaches, migrating large joint aches, neck pain or stiffness, swollen glands, visual changes, tingling or numbness of extremities, or a form of facial paralysis termed Bell's Palsy. "In up to 8% of patients, ... Cardiac complications of Lyme disease generally occur in this early phase and include conduction system disturbances, myopericarditis and congestive heart failure."⁹ Those with cardiac involvement can present with shortness of breath, irregular heart rate, chest pain, light-headedness and/ or fainting episodes.

If left untreated, late stage Lyme disease sets in from weeks to months, and in some cases even over a year, after the initial tick bite. The most common presentation is swelling of one or more large joints (arthritis), with the knee being the most commonly affected joint. The patient can present with symptoms of severe headache and sore or stiff neck if they have developed meningitis. Neurologic involvement can also be signaled by confusion, decreased concentration, disorientation, poor short term memory or mental fog.¹⁰

So, given the pervasiveness of deer ticks, what can we do to protect ourselves from getting Lyme disease? We can attempt to avoid areas of woods, shrubs, leaf debris, and tall grasses but that is not easy in New England. If we do go into these areas, particularly in the months of May, June, and July, it is wise to wear light clothing complete with hat, long sleeved shirt tucked into long pants, pant legs tucked into socks, and preferably boots instead of sneakers or sandals. Stay on the trails to minimize contact with shrubs and grasses. Wear insecticide. You can apply 20-50% N-N-diethyl-meta-toluamide (DEET) to clothing and exposed skin. Permethrin, a chemical that kills ticks on contact, can be applied to shoes, clothing, tent surfaces, mosquito netting, and gear. It cannot be applied to human skin. Treat your pets with veterinary-approved products such as Front Line™ or Advantage™, to minimize their exposure to ticks. Check them and yourselves before entering the home, to avoid transport into the home. DAILY tick checks are essential, as ticks need to be attached to the host for a minimum of twenty-four hours in order to transmit infection.¹¹ These tiny critters attach to unusual places such as armpits, belly buttons, buttocks, and groin. A trusted friend needs to literally "CHECK YOUR BACK."

There are specific recommendations for children in regards to insect repellents. Never apply insecticides on infants under the age of two months. "Oil of lemon

eucalyptus products are not approved for children under three years of age... When using repellent on a child, apply it to your own hands and then rub them on your child. Avoid children's eyes and mouth and use it sparingly around their ears. Do not apply repellent to children's hands. (Children tend to put their hands in their mouths.) Do not allow young children to apply insect repellent to themselves; have an adult do it for them. Keep repellents out of reach of children. Do not apply repellent under clothing. If repellent is applied to clothing, wash treated clothing before wearing again. (May vary by product, check label for specific instructions.)¹²

Okay, you've done the tick check and have found an embedded tick. EGAD! Panicked parents call our office in a panic. Fathers yank off the ticks with aplomb, only to find residual mouth-parts. YIKES! They dig and dig, and then the child comes in with a skin infection from the vigorous attempts at removing every last vestige of *Ixodes dammini*. I think that the Center for Disease Control's recommendations for tick removal are clear and concise:

"There are several tick removal devices on the market, but a plain set of fine-tipped tweezers will remove a tick quite effectively. Prompt and proper tick removal is very important for preventing possible disease transmission.

How to remove a tick:

1. Use fine-tipped tweezers and protect your fingers with a tissue, paper towel, or [preferably non-] latex gloves. Avoid removing ticks with your bare hands.
2. Grasp the tick as close to the skin surface as possible and pull upward with steady, even pressure. Don't twist or jerk the tick; this can cause the mouth-parts to break off and remain in the skin. If this happens, remove the mouth-parts with tweezers. If you are unable to remove the mouth easily with clean tweezers, leave it alone and let the skin heal.
3. After removing the tick, thoroughly disinfect the bite and your hands with rubbing alcohol, an iodine scrub, or soap and water.



Avoid folklore remedies such as "painting" the tick with nail polish or petroleum jelly, or using heat to make the tick detach from the skin. Your goal is to remove the tick as quickly as possible—not waiting for it to detach."¹³

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LEVEL 195

Written by Cadet 2d Lt Sean Mullane, NER-MA 007

The wind whistles in-between the metal girders high above us as the elevator doors open. The inside is lit a dull green, with bare metal walls and a small hatch in the ceiling. Instead of floor numbers, this elevator has numbers much higher than any regular office building. Starting at 90, 130, 195, 200, 250... These numbers are in feet.

My stomach lurches as the elevator leaps upward, traveling faster than most normal elevators. Standing there, I can't help but think of the people who have stood in this elevator, among whom are the first men to walk on the moon.

The elevator stops with a jolt. The doors open as the high-level winds blast at us, approximately 195 feet above the ground.

Looking down, I see a sight that makes my stomach flop: I look down—and down, and down, and down... The floor resembles the type of metal used on catwalks, with small spaces in-between that reveal floors below yours.

Painted on the floor is a thick, yellow stripe, known to astronauts as the “Yellow Brick Road.” It has black arrows pointing to my right. Following it, we come to a strange contraption: six large baskets, each large enough to hold a man, attached to a thick, steel cable. One end of the cable is firmly anchored to the gantry. The other end is fastened to a short, vertical metal pole located at ground level about 1,200 feet away. In the distance, a net is visible, ready to catch each basket as it zips at a frightening speed down the wire.

I am standing on floor 195, the level of the gantry to the Space Shuttle Endeavour, pad 39B. What I am describing are the famed “Escape Baskets,” used by astronauts in case of an emergency on the pad. Going down these baskets is *not* a good experience.

When testing, NASA used only life-sized dummies to determine the major effects of descending down a 1,200-foot wire at high velocity. The dummies traveled from 195 feet to sea level in a few seconds and survived their journey.

Major General Charles F. Bolden, USMC, is the only astronaut to have actually gone down an escape basket. Fortunately, Bolden was not using it in a life-threatening emergency, but he did test the system. An STS-41D had an engine shutdown just after main engine ignition. A small fire had developed on the pad. Bolden utilized the escape system and lived to tell about it.

The “White Room” is, in fact, white (in case any of you were wondering). It's quite a small room, with barely enough room for five people. There are a few

cubbies, a chair, a security camera, and a sticky mat that collects dirt off the bottom of booties before entering the shuttle.

Ducting equipment and electrical wires run from the room to the open hatch. There is a small board that leads to the space shuttle.

The inside looks like organized chaos. Everything has been tilted 90 degrees, so your sense of direction is thrown off. The cockpit is to your right instead of above you. The latrine is below you instead of to your right. The couches on the walls are folded up and will be placed in different positions for launch.

It's pretty hard to scramble across the board without hitting anything. You've got to be pretty careful, because you don't want to hear "Uh-Oh..." from a person lying half in and half out of a space shuttle any more than you want to hear it from, say, a brain surgeon, or maybe a nuclear physicist.

There are wires and ducts everywhere. It doesn't really look like the scenes you see of astronauts floating in front of the windows, seeing a beautiful, blue Earth behind them. Those vistas come later... About two hundred miles later!

Scooting back into the White Room, we exit and walk onto the gantry. Turning around, the massive ET (External Tank) looms behind us. Looking over the edge, I see the launch pad about 100 feet below. The ground is another 90 feet below that.

I just described my experiences on Pad 39B. In July 2009, I had the fortune of being offered a tour by representatives from the United Space Alliance. Touring facilities such as the SSPF (Space Station Processing Facility) and Pad 39B gave me the privilege of being able to see how NASA prepares the shuttle and parts of the space station for flight into space.

In July 2009, there were only five space shuttle flights left. As you know, the STS (Space Transportation System) program has drawn to a close. The Constellation Program, slated to take its place, would have used *Ares* rockets to transport astronauts to the Moon. However, on February 1, 2010, President Barack Obama proposed to cancel this program. Sadly, the NASA Authorization Act of October 10, 2010 brought the Constellation Program to an end.

The story of manned space flight is fascinating. Having had this opportunity, I urge any cadets that get a chance to visit the Kennedy Space Center in Florida. Here, the history of space exploration comes to life. Spend some extra money and dine with an astronaut. It is an amazing experience!



Then Cadet Technical Sergeant Sean Mullane marvels at the size and power of the external tank (ET) and two solid rocket boosters. July 2009.



View from the top of the gantry. The external tank of space shuttle *Endeavor* towers over Kennedy Space Center.



Three-time shuttle astronaut Col Mike Mullane (USAF, Ret) with his grandson Sean looking through *Endeavor's* open hatch while on Pad 39B. July 2009.