

## **EXECUTIVE SUMMARY**

### **AIRCRAFT ACCIDENT INVESTIGATION**

**B-1B, S/N 86-0136 MISHAP**

**7TH BOMB WING, 28TH BOMB SQUADRON, DYESS AIR FORCE BASE,  
TEXAS**

**30 NOVEMBER 2005**

On 30 November 2005, a B-1B aircraft, S/N 86-0136, on a training mission from Dyess Air Force Base, released a Bomb Dummy Unit (BDU)-33 training munition on the impact area of the Melrose Bombing Range (MBR), located approximately 24 miles west of Cannon AFB. The munition landed in its intended area but the munition's spotting charge started a fire that became uncontrollable due to existing hazards and inadequate resources to suppress the fire. The resulting wildland fire burned for about 12 hours consuming approximately 26,000 acres of mostly grazing and farm land. During the fire, privately-owned structures, farm equipment, fencing, wells, livestock, animal feed, and crops were destroyed or damaged. The fire resulted in no human fatalities and one civilian firefighter suffered a broken ankle. Over 195 firefighters from 19 civilian fire departments, 3 federal agencies and the Cannon AFB Fire Department were involved in suppressing and extinguishing the fire.

The 27<sup>th</sup> Fighter Wing is responsible for operations at the MBR. Small range fires are routinely controlled and extinguished by MBR assigned firefighters. Since fires were routinely controlled and extinguished at the range, the risk of an uncontrollable fire was never seriously considered by Operations Support Squadron (OSS) or Civil Engineer Squadron (CES) leadership and there was little motivation to correct known deficiencies.

On 30 November 2005, the risk of an uncontrollable fire was high due to a myriad of factors including: an understaffed MBR fire department, inoperable communication equipment, a large amount of combustible material on the range due to vegetation overgrowth, and high winds. Despite all of the existing hazards, the range did not have procedures to restrict bombing operations and permitted an aircraft to drop practice munitions known to start fires, when the fire condition and risks exceeded the capabilities of the resources available to control a potential fire.

The Board President found by clear and convincing evidence that this mishap was caused by the OSS and CES leadership's failure to appreciate the level of fire danger and implement reasonable safety measures to mitigate the risk of an uncontrollable fire at the range in an application of the principles of Operational Risk Management. A number of DoD recognized human factors present in the mishap wing prevented critical safety related information from reaching senior wing leaders, making conditions at the range ripe for an uncontrollable fire.

*Under 10 U.S.C. 2254(d), any opinion of the accident investigators as to the cause of, or the factors contributing to, the accident set forth in the accident investigation report may not be considered as evidence in any civil or criminal proceeding arising from an aircraft accident, nor may such information be considered an admission of liability by the United States or by any person referred to in those conclusions or statements.*