

It Can't Happen to Me!

Submitted by Safety Department aboard USS Harry S. Truman (CVN-75)

It was early on the morning of Nov. 26, 2004. The ship had been conducting normal operations in support of Operation Iraqi Freedom. We were starting another routine aircraft move, re-spotting the deck after normal flight operations. Thinking everything was “routine” should have been my first clue that something was not quite right.

We had been conducting cyclic operations from noon to midnight every day, and today was no different. We had settled into our routine since arriving in the area two weeks prior. We usually re-spotted the deck after the last recovery.

I had reported aboard in May 2004 and recently had completed 90 days TAD to the Supply Department as an FSA.

I only had been back on the flight deck as a blueshirt for a few weeks; yet, I felt comfortable on the flight deck and in my job.

The move crew was told to re-spot an S-3 Viking from the point to deck-edge elevator 1. After the tow bar and tow tractor were hooked up, the aircraft director gave the signal to pull the chocks and chains, and the aircraft was broken down and prepared for movement.

As the S-3 started to roll, I noticed a chain was in the way of the tire. Instead of blowing my whistle to stop the move, I incorrectly decided to fix the problem by trying to reach under the rolling S-3 and grab the chain. I misjudged the proximity of the tire to my hand and the “speed” of the slow-moving aircraft. My reaction was not as fast as I thought, and, as I grabbed the chain, the tire ran over my hand.

The pressure and weight of the aircraft blew open the palm of my hand. The pain was excruciating.



After being evacuated from the flight deck, I underwent emergency surgery on board to fix my wrist and to stitch up my hand. I then was flown to a local hospital for further surgery to repair my hand. I'm glad I was wearing my



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gloves, which gave me some protection and prevented oil, grease and dirt from getting into my open wounds. I feel extremely lucky to have only received broken bones in my wrist and fingers.

Had I followed wing-walker procedures, including blowing my whistle to stop the aircraft movement before reaching under the moving aircraft, I could have avoided this mishap. Had the aircraft run over the chain, there would not have been any damage to the chain or the plane's tire.

This mishap underlines the importance of PQS, OJT, and supervision by the move director. Follow the tried-and-true procedures that often have been written in blood, in this case, mine! ✨