

Lack of Time-Critical ORM

By PR3 (AW) Dusty Rather

One warm day in April, the Sailors of VAQ-139 were tasked with the arduous job of replacing the starboard engine on one of two aircraft on det at a forward air base in Iraq. We had been operating as a split squadron between this base and our carrier in the northern Arabian Gulf, so those of us in the desert sometimes had to make-do with the people available. This engine swap was no exception; although, we would come to wish it had been.

Making this job an “all hands” effort, we soon installed the new engine and had the jet ready to fly. On the final phase of the swap, and when the defective engine was to be placed into a transport container and sent to AIMD, we had a serious lack of communication. That problem could have brought on disastrous results.

The four other shipmates and I weren’t faced with equipment failure or any kind of weather interference; rather, it was a common item involved in most naval



aviation mishaps: human error. We had not discussed thoroughly the steps in the process for removing the main-engine sling once the engine was in the crate. With only one AD on the scene, most everyone involved had little to no experience or even a basic understanding of what needed to happen with this engine and when. However, with the AD's guidance, we mounted the engine in its container and unbolted the hoist sling from the engine.

The mech in charge of this process told me the sling was light, and we should be able to pull it off. His plan was to lift one end of the engine sling just enough to let us slide it clear. He positioned himself and prepared to lift one end of the sling.

About that same time, I noticed one of the other guys was reaching between the sling and the engine to retrieve a dropped bolt. Not seeing this action but ready to remove the sling nevertheless, the AD yelled, "Ready?" Before I



could tell him to wait for the other guy, he lifted his end of the sling up. Realizing the weight was too much for him, though, he immediately dropped it back down. Our shipmate who had been reaching for the bolt quickly pulled back his hand and saved it from being crushed.

A few excited words were exchanged, and tempers flared. The discussion was short-lived, and we quickly determined that we needed to communicate more effectively the next time, or the next person's reflexes might not be as good.

Although we had dodged a serious injury, the point of this story is that Sailors need to learn from near-misses, as well as real mishaps. We also learned that we must use ORM while going through every maintenance task beforehand. Determine the correct procedures, and make sure everyone understands their roles. It also is critical to communicate and make sure the work area is clear of hazards. We then need to adjust the plan as things change (what's different today). What obstacles exist, and how we can avoid them to reduce risk.

Communication can be the strength or the death of any crew or squadron. Had we used the five steps of ORM (identify hazards, assess risk, make risk decisions, implement controls, and supervise), this task never would have reached the point where a Sailor was in jeopardy. 🚫

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Good example of what should have been a five-step ORM review becoming time-critical.—Ed.