

Sailors and Marines Preventing Mishaps

BRAVO Zulu

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AD3 Jacoby and AD2 Jarvis HSC-2

Petty Officer Jacoby was flying as the crew chief on Redhawk 732. While in straight and level flight, he heard a strange noise coming from the transmission area. He immediately investigated the noise and called for a check of the gauges. No one else heard the noise, and no other indications were noted. After 732 safely landed, Petty Officer Jacoby inspected the transmission and tail drive-shaft areas, discussed what he had heard with maintenance control, and convinced them to investigate further.

With little information to help, Petty Officer Jarvis meticulously inspected the transmission and tail drive-shaft areas. He found the transmission oil cooler had rotated, the belts were loose, and an oil line was rubbing on the airframe.



AM2 Daniel Dominguez HM-15

After a hydraulic line for the main-rotor-blade fold on an MH-53E ruptured, Petty Officer Dominguez was called to clean up the massive hydraulic leak. While cleaning the pylon section of the helicopter, he found two cracks in the skin of the aircraft.

Petty Officer Dominguez immediately notified maintenance control and quality assurance, and the cracks were "stop drilled," allowing the aircraft to continue its mission and preventing a catastrophic failure.



ADAN Misha McMath HSC-28

While doing a routine maintenance inspection on Ghost Rider 41, Airman McMath found a cracked inner race on the bifilar assembly for the main rotor head. She immediately reported the downing discrepancy to maintenance control.

Her keen attention to detail resulted in her finding a problem that was not clearly obvious, could have been missed easily, and would have had potentially catastrophic results.

**Ordnance Mechanic-Artisan John Collandra
Naval Air Depot, Jacksonville**

While inspecting and overhauling a BRU-14A, Mr. Collandra had to replace an auxiliary-unlock-switch assembly. After removing the replacement part from the shipping package, he did a pre-installation inspection of the component, even though that step was not part of written procedures. Looking inside the threaded M55 CAD hole for the unlock spring, he didn't see it.

The part was disassembled, uncovering a factory defect. Because the assembly uses a shear wire, no mechanical check of the unlock assembly is done once the BRU is assembled. Had this discrepancy gone unnoticed, the spring position would have locked the store to the rack, preventing release of a loaded weapon. His actions led to Aviation Armament Bulletin (AAB) No. 709.



**AMAN John Thaves
HSL-42**

Airman Thaves discovered a missing cotter pin on the yaw channel of the mixing unit of Proud Warrior 430 during a 56-day inspection. A closer inspection showed the bolt had broken torque standards.

Had this discrepancy gone unnoticed, it could have resulted in catastrophic failure of the tail-rotor, flight-control system.



**AD3 Mark Fronda
VAW-113**

Petty Officer Fronda found a crack on the propeller of Black Eagle 600 that, if left undetected, could have led to the loss of the aircraft.

He discovered the problem while doing a corrosion inspection on the No. 3 blade of the port propeller assembly. He first noticed what appeared to be a hairline crack in the fiberglass on the camber-side inspection window. But a closer look revealed that the crack ran beyond the length of the front propeller inspection window and along the spar line.



**PR2(AW) Gary Vaughn
AIMD, NAS Jacksonville**

Petty Officer Vaughn was tasked to fix a loss-of-vacuum discrepancy on a thin-pack parachute. Upon pulling the ripcord, the pilot chute did not deploy. Taking a closer look, Vaughn found the top and bottom container flaps had been tacked together, keeping the parachute container from opening. At this time, he advised QA of this life-threatening maintenance malpractice and completed a hazardous-material report, making sure the fleet was aware of this serious problem.



PRAN Elizabeth Holmes
VAQ-139

During a 14-day special inspection on the ejection seats of a recently received aircraft, Airman Holmes noticed the tacking on the parachute ripcords was incorrect on all four seats. Knowing the jet needed to be flown the following morning, she coordinated with AIMD to elevate the work request to a priority-one status. The parachutes were repaired and reinstalled in the aircraft in time for the next day's flight schedule. Had this mistake not been caught, the parachutes inadvertently could have deployed inside the cockpit, restricting the pilot's ability to control the aircraft and making a safe ejection impossible.

AMEAN William Hoye
VAQ-139

Airman Hoye found the hand wheel for the top-latch mechanism still installed on the pilot's ejection seat on an aircraft loaned from another squadron. Knowing this condition was unsafe, he quickly alerted the night-check supervisor and maintenance control. Had this problem not been caught and had the aircraft performed a negative-G maneuver, the pilot's seat could have risen up the seat rails, triggering the command ejection sequence for the other three crewmen. While the rest of the crew would have completed the ejection sequence, the pilot would have been left only partly ejected.



AME1(AW) Diane Laraby
VAQ-139

While preflighting Warcat 503 during a squadron detachment to NAS Fallon, Nev., Petty Officer Laraby discovered the cross-shaft retaining nut from the ECMO-3 ejection seat was missing. She quickly notified maintenance control and initiated a FOD inspection. Only after pulling the seat did she find the nut. The seat then was repaired and reinstalled in minimum time, allowing the squadron to complete all scheduled sorties. If this discrepancy had gone undiscovered, it could have caused catastrophic failure of the seat.

ATAN Rouving Kongsima
VFA-143

Airman Kongsima was preparing Dog 101 for the day's flight schedule and keying confidential codes into the aircraft. Once given the signal that the cockpit switches had been checked, he applied shipboard power. Upon applying the power, he immediately noticed the aircraft's wings began to spread. Two aircraft were parked adjacent to and within less than a foot of DOG 101.

Realizing that damage would have been inevitable for all three aircraft, Airman Kongsima quickly responded, removing power and preventing more than \$1 million of damage.



**AM1(AW) Travis O'Dell
VP-45**

While operating at Al Udeid Air Base, Qatar with VP-45, Petty Officer O'Dell watched as a Royal Air Force Tornado developed a hydraulic fire on its main undercarriage shortly after landing. The rapidly developing fire was not immediately apparent to the crew in the cockpit. Petty Officer O'Dell, who was driving along an adjacent perimeter road at the time, quickly realized the severity of the situation and jumped into action. Locating the nearest fire bottle, he dragged it a considerable distance to the burning aircraft. With the assistance of the crew, whom he since had alerted to the emergency, Petty Officer O'Dell managed to extinguish the fire before it had time to destroy the aircraft.



**AM1(AW) Chad Beck and AW3 Timothy Hollis
HM-15**

During a routine phase inspection on an MH-53E, Petty Officers Beck and Hollis were inspecting the tail rotor pylon when they found a bullet located on a pylon rib and an entry point in the top of the tail gearbox cowling. They immediately notified maintenance control and QA of this situation.

Their keen attention to detail led to the discovery of FOD and a damaged gearbox, preventing serious injury to personnel or potential loss of aircraft.

**AMEAN Matthew Hamilton
VQ-4, Detachment NAS Patuxent River, Md.**

Airman Hamilton was doing his final inspection on the alert launch of Shadow 409 when he noticed the "T" handle still was installed in the nose landing gear. He immediately notified the aircrew to resolve the situation.

With the "T" handle installed, the aircrew would not have been able to retract the nose landing gear.



**AOAN Mark Kirchner
VFA-136**

While assigned to the CVW-1 arm/de-arm team, Airman Kirchner successfully identified two improperly loaded CATM-9X missiles on aircraft seconds before launch. These discoveries prevented possible injuries and loss of valuable training assets valued at more than \$316,000. He displayed the professional behavior and characteristics found in more senior ordnancemen.





**AM1(AW/NAC) Kenneth Jay
VR-56**

Petty Officer Jay began a normal preflight of a C-9B Skytrain. During his inspection, he checked the crew oxygen system for proper quantity and flow through the installed masks. He discovered that the flow from all three flight-crew positions was weak at best. He also noticed that the LOX quantity gauge for the crew side indicated 8 liters, which would reflect a sufficient amount for the assigned mission.

After some troubleshooting, Petty Officer Jay found that the preceding nine "A-sheets" reflected the identical amount. This situation raised a flag, warranting further investigation. Petty Officer Jay immediately notified maintenance control and work center 130.

The 130 shop found the LOX bottles empty, and the gauge was stuck on the 8-liter mark.

**AME3 Chad Petersen
VAQ-139**

During a pre-launch inspection of aircraft 501, Petty Officer Petersen noticed an anomaly with the main landing-gear doors. Despite being well beyond his normal area of responsibility and training, he discovered a broken aft lock-attachment lug on the port, forward main-gear door.

Had this discrepancy gone undiscovered, it could have caused catastrophic failure of aircraft 501's landing gear.



**AT2 Jacob M. Dobbs
VAQ-139**

While doing a routine maintenance on aircraft 500 at NAS Fallon, Nevada, Petty Officer Dobbs noticed smoke coming from the station No. 1 jamming pod. It started after ground electrical power was applied.

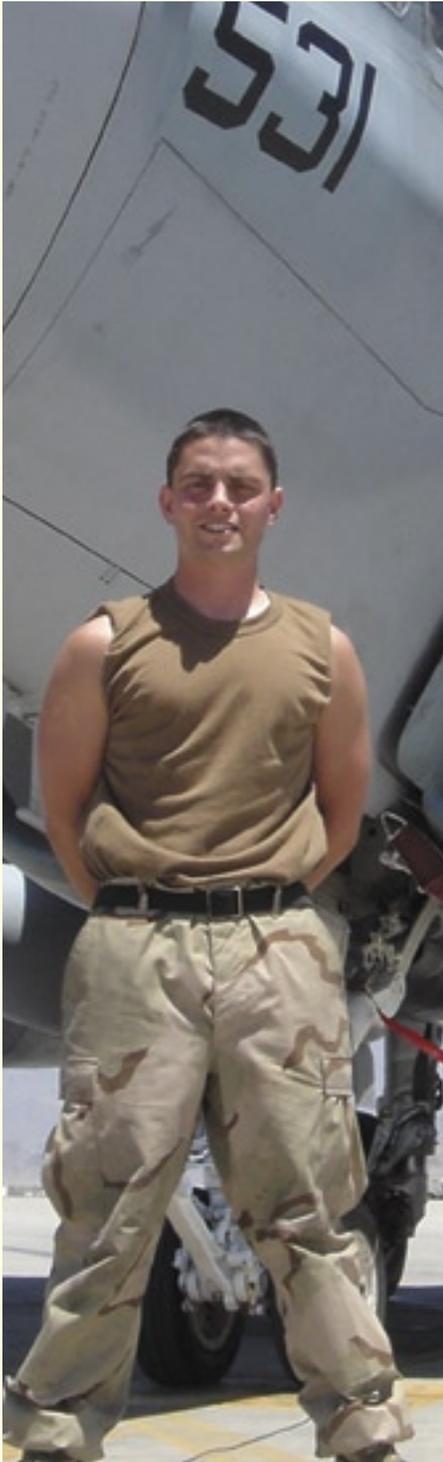
Petty Officer Dobbs immediately removed electrical power, exposed the internal hardback wiring, and extinguished the fire.

**AE2(AW) Larry Lowry & AM2(AW) Jamie Cain
VFA-143**

Petty Officers Lowery and Cain were troubleshooting a rudder-pedal binding discrepancy on Dog 105. During the inspection of the cockpit, Petty Officer Lowery saw something sticking out of the bulkhead in the port rudder-pedal area.

As he moved the pedals, he immediately noticed that there was only about one-eighth-inch of movement. Upon further inspection, they noticed that an avionics cooling-fan filter caused the binding situation on the port rudder pedal. Petty Officer Cain also found one of the mounting tabs on the filter housing was bent because of excessive contact with the rudder pedal, causing extensive wear marks.





**AN Brandon Crysell
VAQ-133**

During a pre-flight inspection of aircraft 532, Airman Crysell discovered a rivet stem laying on the outboard speed-brake fairing. Had this rivet been missed, it could have lodged in the speed brake, resulting in aircraft asymmetry and loss of flight control endangering aircrew.

**AD1(AW) Ronald James
VAQ-133**

Petty Officer James noticed a British Tornado with hot brakes was being directed to park next to one of his EA-6Bs. He immediately directed the aircraft be sent to the hot-brake area and relayed this information to Maintenance Control, so the NAS Whidbey Island Fire Department could be notified.



**AA Claude Gibbs, AA Omar Redd, AA Michael Mordecai, AA Christopher Cox, AA Daniel Garcia, and AN Nicholas Hebdo (not pictured: AN Ryan Clayton and AR Paulo Adela)
VAW-113**

VAW-116 called VAW-113's maintenance control to warn them that a wells unit was on fire. Airmen Clayton and Nicholas; Airman Apprentices Hebdo, Garcia, Redd, Cox, Mordecai, and Gibbs; and Airman Recruit Paulo Adela responded immediately. They quickly moved Black Eagle 602 out of harm's way and then helped the fire-fighting crew put out the fire.