

Under PRESSURE

By AME3 Daniel Kennedy, VFA-86

I had been on leave for seven days, and despite a restless night of sleep, everything seemed to be running smoothly when I got to work. It was a beautiful day, and we had only a few small tasks to complete before FOD walkdown. Little did I know it was to become a day I soon would not forget.

During pass down, AME3 Tillman and I were told to refill the radar liquid-cooling filtration unit (LCFU)



Lid with stenciling added by VFA-86 to warn personnel before servicing is performed.

to prepare an FA-18C radar for decontamination. Our LPO reminded us to depressurize the LCFU before filling it. AME3 Tillman and I checked out the pre-op card and the required toolbox.

As we headed out to the hangar, we made our first mistake. We left the correct technical manual sitting on the desk. The LCFU is known to be a hazardous unit that requires strict adherence to the publication because nitrogen is used to pressurize the unit. This topic has been covered in at least two hazreps, the latest from VFA-83. It also has been the subject of recent squadron safety training. Without the technical manual, we had no reference to verify we were doing the job safely.

Upon arriving at the LCFU, AME3 Tillman started loosening the front bolt from the band clamp on the refilling reservoir. Once it was loose enough to spin by hand, he handed the wrench to me. As I began

to undo the back bolt, everything went wrong. We had missed one of the first steps in the technical manual that says, “Open LCFU make-up reservoir bleed valve to release any built up pressure.”

A thunderous boom resounded in the hangar bay as the lid flew off and hit AME3 Tillman in the face. I immediately turned to assess the situation and saw AME3 Tillman cupping his face in his hands, with torrents of bright-red blood gushing from behind his hands. The blood was collecting at his feet. I immediately ran to the shop for clean, lint-free rags to stop the bleeding. While in the shop, I informed the LPO and day-check supervisor that AME3 Tillman was hurt and needed medical attention.

We applied direct pressure to stop the bleeding, and I drove AME3 Tillman to the emergency room. After several internal and 12 external stitches, X-rays, and a CT scan, AME3 Tillman was released from the hospital. To this day, he remembers little of the incident, but he remembers the effects every time he looks in a mirror. He was lucky that day; a half-inch left or right and he could have lost his sight.

In the future, I will heed the hazards presented during pass downs, safety training, and within hazreps. They are published so personnel can apply the ORM process. We missed a step because controls were implemented in the form of checklists, and we failed to follow them. It does no good to have a publication if it isn't the correct one for the job, if steps are skipped, or if the manual is in a work center while you perform maintenance tasks. We also have a recommendation for the fleet: Stencil the lid of the LCFU with a red-letter warning to release the pressure before loosening the lid. We believe some external marking or warning might help prevent future incidents with the LCFU.

Neither AME3 Tillman nor I will forget this mishap. You must follow checklists and pay attention to hazreps. Don't have a repeat incident at your command.

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