

# Crew Resource Management

Decision Making  
Assertiveness  
Mission Analysis  
Communication  
Leadership  
Adaptability/Flexibility  
Situational Awareness



## A Sobering Piece Of Irony

By LCdr. Anthony Staffieri

Just when I thought the pocket rocket never could do me wrong, it did. Actually, it really wasn't just the PCL's fault but a combination of all those things we try to avoid or don't think can happen to us. I'll set the scene in a moment, but let me start by providing a little career background.

After my first VS tour, I headed over to P'cola for NFO instructor duty. It was a good tour that allowed me to hit all the wickets: head NFO flight scheduler, IUT instructor, and finally the standardization and NATOPS officer. I even got chosen as instructor of the year. I then spent more than two years with Commander Second Fleet in Norfolk. Talk about leaving aviation altogether, this place would make you forget you had a home. It was swarming with SWO daddies and demanded long hours, but the tour was incredibly eye-opening as to how the real Navy works. Other than the gold wings on my khakis, the fact I was a brown-shoe quickly faded to the back of my mind.

I finished that tour with some polished turboprep skills, and then I was off to the wing for "temporary duty." I stayed there for a year and a half and didn't start FRS training until one year into the tour. I then spent three months post-FRS at the wing, going from one back-in-the-saddle (BIS) to another. I was more than three and a half years out of the cockpit. Combine those three years of not flying with multiple BIS hops, and it's easy to overestimate anyone's currency and proficiency.

Flash forward to my current tour. Because my squadron essentially was in limbo until decommissioning, no work-ups or high-tempo ops were headed our way. That meant after being in the squadron for about two weeks, I had flown maybe three times, none at night. My first night flight (form-tanking mission) was with a nugget pilot. The flight came and went uneventfully—well, kind of. When I say "kind of," I mean up until we lowered the gear in the overhead on our final landing of the night. We had an unsafe nosewheel indication.

Let me mention the S-3 and gear position-proximity switches never have performed well together, but rarely have they led to an actual collapsing of the gear.

The good news was we had a wingman, and we were over our home field. Surely nobody else would be landing at 2100; all the other Jacksonville-based squadrons no doubt were at home watching "Lost."

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Unfortunately, my personal episode was just beginning.

Before doing anything, we climbed into a delta pattern and called for our wingman to join. I started to coordinate with tower, the other aircraft, and our SDO, so that everybody would be on the same page—at least that was my intention.

On join-up, our wingman said it looked like the gear were down, with good indexers on the nosewheel. That's a good sign the gear really is down and locked, but good headwork still drives a crew to the PCL just to be sure nothing is missed.

While the pilot maintained pattern altitude, I broke out the PCL. I figured it only should take a minute to locate the procedure and make sure we were doing the correct steps.

As you would expect, considering our situation, I was assigned a tower controller who felt the need to be in the cockpit, even while he dealt with what was becoming a seemingly busy airfield. As we marshaled overhead, a Cessna and P-3 showed up for landing work.

Little did I know that pulling out the PCL at night for a relatively benign problem would test my comprehension of the English language. It was also a test of the helmet-fire system. These are two easy tests to recognize and pass, if you know you're taking them. I saw these tests regularly as an instructor with flailing studs, but I didn't think they still applied to me. And hey, that CRM thing applies only when you can remember the letters, right?

Essentially, my biggest problem was I couldn't seem to locate the correct abnormal-gear procedure. I had found every abnormal-gear procedure in the PCL but the one I needed. Remember that English comprehension thing? The hair stood up on the back of my neck for the first time in 1,500 hours of flight time, and I could do nothing about it. When I couldn't locate a procedure, I asked our wingman and SDO to lend a hand. Unfortunately, that query didn't provide a solution either, because somewhere in the process, I evidently didn't give them all the info they needed to help me. What about the pilot, you ask? Funny, I never thought of asking him if he'd look through the PCL. I mean, if the SDO, wingman, or I couldn't find a procedure, the pilot didn't stand a chance, right?

Suffice it to say, we felt (I think) confident enough the gear was down and locked, so we headed for the

runway. Fortunately, the gear was down and locked, but even better was the fact there actually was a procedure for this abnormal event. I didn't figure that out, though, until after I handed the pilot my PCL in the holdshort and said, "Go ahead, you find it." He did find it. He turned the page—a simple task neither the SDO, wingman, nor I apparently could do. Yes, proximity switches fail often in the S-3 world, but what if it wasn't a proximity switch this time? I'd probably be writing this as one of those SWO daddies, wearing black shoes.

A lot was learned from this flight for all paygrades. In this case, the five-step ORM process and just a dash of



Photo by PHAN Chris M. Valdez. Modified.

CRM would have been helpful had I actually used them. As a crew, we never voiced ORM in the cockpit; how many people do? We had more than enough gas, more than enough time, and plenty of outside help to combat this problem, but we let a "demanding" controller and lack of good judgment determine our actions.

CRM—how simple would it have been to hand the PCL to the pilot while overhead? Once on the ground, it took him only 30 seconds to find out what I had been doing wrong. Why didn't I do that in flight? Why didn't he pull his PCL out and back me up? It seems really simple and almost unbelievable two qualified crew members could mess up something that seems so basic. This scenario hammers home the fact that 80 percent of all mishaps are caused by aircrew. It's a sobering piece of irony to know the aircrew avoided a mishap because the airplane rushed in to the save the day. 🦅

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