

Sailors and Marines reducing mishaps

BRAVGO Zulu



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AD3(AW) Thomas Banach VFA-83

While serving as a power plants technician in VFA-83, Petty Officer Banach was tasked with doing an engine turn after another maintainer had finished the pre-inspection and had installed the turn screens. Knowing that he personally had not done the initial inspection, Petty Officer Banach decided to re-inspect the aircraft and found FOD in the No. 1 engine intake just forward of the vortex generator. Had he been less diligent and skipped his own pre-inspection, this FOD would have caused serious damage to the Hornet's engine.

Petty Officer Banach's keen attention to detail and by-the-book maintenance saved the Navy \$1.3M in repairs, dozens of wasted man-hours, and possibly a life.



SSgt. Everett Cooke and Sgt. Daniel Ellison HMH-361

While on deployment in Iraq with HMH-361, SSgt Cooke was serving as crew chief on a routine night logistics mission. The command was moving Marines and equipment from a nearby forward operating base (FOB), and the mission went off without a hitch. After shutdown, he began his daily inspection and found a castle nut had not been installed on the bell crank for the collective flight control. A conditional inspection was done on all flight-control components to check for security and integrity.

During this inspection, Sgt. Ellison noticed that a cotter pin was missing on the servo input for the tail rotor. These two Marines identified and corrected maintenance discrepancies that could have had catastrophic results.



AM2(AW) Steven M. Floyd VFA-192

Dragon 305, an FA-18 Hornet, was being turned around for launch on the next cycle. Petty Officer Floyd discovered the mechanism bolt for the connecting link on the main landing gear planing arm had sheared at the nut section. He immediately notified the flight-deck coordinator, who then contacted maintenance control. A combat FOD walkdown was done, and the sheared section of the bolt, along with the nut and locking tab, was recovered from the landing area. The aircraft immediately was downed. Had this discrepancy gone unnoticed, it could have caused a catastrophic failure of the landing gear.



**Cpl. Christopher Pierce and LCpl. David Noble
HMM-264**

While operating at Al Asad Airbase, Iraq, LCpl. Noble and Cpl. Pierce did a daily and turnaround inspection on a CH-46 scheduled for a functional check flight (FCF). As part of the standard inspection of the control cables, LCpl. Noble found a flat spot on a lateral control cable. Cpl. Pierce confirmed the cable was rubbing against an airframe spar. A more detailed look revealed 5 broken strands of wire that were not visible initially. These strands were broken in a critical fatigue area where even one broken strand downs the plane.

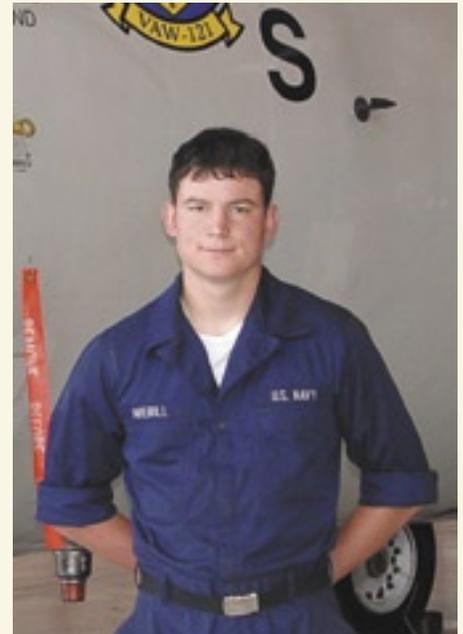
The Marines' alertness, technical expertise, and conscientious efforts toward flight safety prevented a possible in-flight failure and the potential loss of the aircraft and crew.



**AD2 Santos Rivas
HM-15**

Petty Officer Rivas found loose ball bearings in an engine-drain screen on a squadron MH-53E helicopter. He quickly notified quality assurance and maintenance control, stating that the ball bearings could have come from the belt tension idler pulley on the nose gearbox. He also said the aircraft needed to be inspected further to find the source of these bearings.

Already turning, the helicopter was shut down for further inspection. While inspecting the suspect area, Petty Officer Rivas and a quality-assurance representative found it was worn, and the race was missing ball bearings.



**AEAN Brandon Averill
VAW-121**

On the last day of a 10-day detachment aboard USS Dwight D. Eisenhower (CVN-69), AEAN Averill saved the lives of two shipmates.

During the launch of his squadron's E-2C Hawkeye on cat 3, two sailors inadvertently crossed inside the shot line while working a different launch on cat 2. The Hawkeye on cat 3 had a "thumbs up" for launch and was in tension. Before disaster could strike, airman Averill noticed the fouled deck, immediately suspended the launch, and prevented the loss of two lives at the hands of the E-2's propeller.

Airman Averill demonstrated the situational awareness of a seasoned professional even though it was only his third time working the flight deck.

**AE1(AW) Robert Price
VAQ-139**

During a normal daytime launch, the left generator light on NJ 573 would not go off. Petty Officer Price directed the shutdown of the starboard engine to verify the condition of the port generator. Upon doing this, the aircrew lost all electrical power to the aircraft. As he began to troubleshoot the problem, Petty Officer Price found burn marks on the port engine-bay door and led to the discovery of a shorted, primary-phase wire. Had this discrepancy not been detected, it is highly probable a catastrophic electrical failure and electrical fire would have ensued, jeopardizing the safety of the aircrew and causing severe damage to the aircraft.





**AMEAN Joseph Barone
VAQ-133**

While performing the command sequencing-system leak-test during a 364-day inspection on aircraft 530, AMEAN Barone identified a leak. His thorough inspection revealed the command-sequencer gas-transfer line was disconnected from the ECMO-3's ejection seat. This discrepancy, if undetected, could have prevented both rear seats from firing in the event of a command ejection. AMEAN Barone's dedication, initiative, and professional knowledge saved the day and, potentially, aircrew lives.



**AD2(AW/SW) Douglas Wright
HC-6**

During a 28-day special inspection, Petty Officer Wright was inspecting the flexible coupling of the engine's output shaft for cracks. He rotated the No. 1 engine's output shaft and, with the use of a flashlight, searched for any visible signs of a cracked flex plate. He spotted a protrusion and used a scribe to feel for a lip. For confirmation, he inspected the protrusion with a borescope. Not only did he verify the crack, but he also found another smaller crack on an adjacent flex plate. Petty Officer Wright's attention to detail prevented a potential aircraft mishap and led to the aircraft's accurate repair.



**AM2 Chad Mixon
HSL-44 Det 1**

During a routine 30-hour inspection of Magnum 447, Petty Officer Mixon checked main-rotor dampner bearings for axial play. All bearings passed initial inspection with the bearing-inspection gauge. However, a closer look revealed strands of cloth protruding from between one of the bearings and its race.

Displaying uncommon initiative, he investigated further and found that the liner was separating and causing faulty readings from the bearing-inspection gauge. The gauge couldn't penetrate the space between the bearing and race. The dampner was removed and replaced.

Petty Officer Mixon's attention to detail and his willingness to go above and beyond the basic inspection led to finding a problem that could have caused catastrophic failure.



**AM2(AW) Jason Brooks
VAQ-139**

While performing routine post-flight maintenance, Petty Officer Brooks discovered damage to the turbine blades of the port engine of a squadron aircraft. The damage was severe, and an additional flight may have resulted in catastrophic engine failure.

His discovery led to engine removal and replacement, thus averting a potential mishap and possibly saving the lives of squadron aircrew and a valuable aircraft.