

Sailors and Marines reducing mishaps

BRAVO Zulu



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AT1(AW) Larsen and AM2 Whetstone VR-52

During a routine inspection on a squadron aircraft, AT1(AW) Larsen and AM2 Whetstone went beyond the 18-inch rule and inspected the entire open area in the tail section. They noticed a cable-guard pin was worn on the elevator-cable sector.

This area is not on an inspection cycle, and the worn pin could have separated and led to jammed elevator flight controls. Their decision to look beyond the immediate area being inspected prevented a potential flight-control malfunction and possible loss of aircraft and aircrew.



AMEAN Gary A. Baguio, Jr. VAQ-133

During a daily inspection on aircraft 532, AMEAN Baguio discovered the bolt-nut combination attaching the drogue shackle to the scissor shackle assembly on ECMO-1 seat drogue parachute was installed improperly. Had this gone unnoticed, it could have led to a malfunction of the ejection seat's drogue parachute preventing activation in an emergency situation.

AMEAN Baguio's keen eye and superb professional knowledge saved the day and potentially an aircrew life.



AMAN Ishchuk VFA-83

While picking up cleaning gear following a 14-day special inspection, AMAN Ishchuk noticed the forward attaching nut on the starboard-main landing-gear planing-link assembly was in an abnormal position. Further investigation revealed the forward planing-link bolt had been sheared.

If gone unnoticed, this problem could have resulted in catastrophic failure of the starboard landing gear, serious damage to aircraft, and possible loss of aircrew.



ABH3 William Tinsley NAS JAX Base Operations

After escorting an aircraft movement to the high power run-up area, ABH3 Tinsley noticed a large metal object while crossing runway 14/32. He notified tower personnel and retrieved the object.

The source of the FOD was a parking brake actuator from an A/S32A-42 tow tractor assigned to a local squadron. His awareness of his surroundings helped keep the flight line clear and aircraft and aircrew safe.

AN Adalberto Ramirez
VAW-113

AN Ramirez discovered a sheared bolt on the port main landing-gear strut while performing his plane captain preflight walk-around inspection. Further inspection revealed that the drag brace hard-point on the port, main landing-gear strut had departed during its last flight. AN Ramirez immediately notified his flight deck coordinator and downed the aircraft.

His decision prompted the launch crew to prepare another aircraft, allowing the squadron to meet its scheduled sortie. This particular discrepancy was almost undetectable in that it escaped the attention of the assigned qualified plane captain, airframes collateral duty inspector and Black Eagle troubleshooters. Had this discrepancy gone undetected, the potential existed for a catastrophic failure of the landing gear during take-off or landing. AN Ramirez's keen attention to detail saved the Navy potential loss of an aircraft, as well as the lives of the aircrew and shipmates on the flight deck.



AM1 Christopher C. Appling
HM-15

During a routine inspection of an MH-53E attached to HM-15 Det 2 in Bahrain, AM1 Appling noted that "Hurricane 10" had an engine-exhaust nozzle assembly installed on the No. 2 motor but "Hurricane 11" did not. He researched the correct configuration for the engine-exhaust nozzle on the No. 2 motor.

AM1 Appling determined that the nozzle assembly is required only on the No.1 and No. 3 engines, not on the No. 2 engine. In addition to "Hurricane 10," other home-guard aircraft had the same discrepancy, and maintainers corrected it immediately. The exhaust-nozzle assembly could affect proper cooling of the No. 2 engine compartment, which could lead to a possible No. 2 engine compartment fire.



PO3 Brown
VFC-12

While performing a daily and turnaround inspection on a squadron aircraft, Petty Officer Brown discovered a 1-inch long hairline crack in the port main-landing-gear uplock-support bracket. The crack was so slight that it could have easily been dismissed as a scratch in the paint. Had the crack gone undetected, the bracket most likely would have cracked through or broken off, possibly jamming the uplock mechanism and preventing gear extension.

Petty Officer Brown's keen attention to detail certainly prevented further damage and a possible in-flight emergency.



AN Gutzmer
VFA-122

During the final preflight inspection on squadron aircraft AN Gutzmer discovered a missing cotter pin and loose trailing edge flap-shroud bolt on the outboard aileron. He notified airframes personnel, who fixed the discrepancy.

AN Gutzmer also was doing a preflight inspection on another aircraft when the master brake servo-cable caught his attention. Closer review showed the cable was rubbing and misrouted.

In both occurrences, AN Gutzmer's judgment and attention to detail set an example all should follow.



**AO2 (AW) John Vincent and AN Ronald Spears
VAQ-139**

AO2 Vincent and AN Spears were assisting a sister squadron's beach detachment launch a newly accepted aircraft when they discovered two station pylons were extremely loose and unsafe for flight. They immediately notified the squadron's detachment maintenance CPO, who grounded the aircraft possibly preventing the catastrophic failure of both store stations and a Class-A mishap.

Not finished with the task at hand, AO2 Vincent and AN Spears organized a working party and expeditiously unloaded the pod and drop tank, properly torqued both pylons to specifications, and launched the aircraft to Navy Fallon less than two hours after its scheduled launch.



**AN Dan Ehren Bieder
VP-10**

Airman Bieder discovered a hydraulic leak in the aircraft's hydraulic-service center while doing a walkaround inspection of a squadron P-3C. He immediately notified the flight-station crew to secure hydraulic systems.

A closer look revealed the leak resulted from a failed "O" ring in the filter section of the No. 2 hydraulic pump. Airman Bieder's quick and correct response prevented a potential loss of the No. 2 hydraulic system in flight.



**AM3 James A. Royal
VFA-83**

While walking through the hangar bay, AM3 Royal noticed hydraulic fluid on the deck underneath the starboard brake of aircraft 301. Further investigation showed that a tie-down chain had been secured improperly to the hydraulic brake line. The line had become disconnected from the landing-gear axle, rendering the aircraft unsafe to move due to inoperative brakes.

He immediately notified his division chief, then both hangar and flight-deck controls. Upon investigation of other aircraft in the hangar bay, two Hornets were found improperly tied down. Had one of these jets been moved, the brake rider wouldn't have been able to stop the aircraft.

By using proper procedures and common sense, AM3 Royal took the necessary corrective actions to prevent a potential mishap.



**AT1(AW) Jeffrey Samuels
VAQ-139**

Petty Officer Samuels was working as a QAR on NK 501, supervising other maintenance personnel working inside the forward cockpit. Blowing exhaust from embarked aircraft caught the forward canopy knocking it off the guide rails, which began closing on the personnel in the cockpit. AT1 Samuels quickly alerted the other maintainers and together were able to slow the unfettered descent of the 400-pound canopy without injury or damage to the canopy. AT1 Samuels' quick thinking and decisive action was directly responsible for the prevention of a mishap and personal injury.