

Don't Practice What's Not in the Book

By AE2 Matthew Thurston

I was working as the night-check supervisor in the AE shop. When I walked into the shop at the beginning of my shift, I noticed that the AE1, my shop supervisor, had an airspeed indicator in his hand. I asked him, “What’s wrong with that?” He shook it, and a large rattling noise could be heard—not a good thing. The night wasn’t starting off well and would just get worse.

The shop supervisor then told me that a TTU-405 test set already was hooked up to the aircraft. He was giving me the priority for the night.

When a new airspeed indicator was received from supply, I headed out to the aircraft with one of my workers to install it and to perform an operational check.

Arriving at the aircraft, we saw the TTU-405 test set was hooked up through the pitot static-drain lines in the port cheek panel (blue caps in picture), instead of directly to the pitot and static probes. We both thought nothing of the arrangement at the time because it’s a common practice in the Prowler community to hook up the test set to the drain lines. This practice also is being taught to students at AE Initial School at Center for

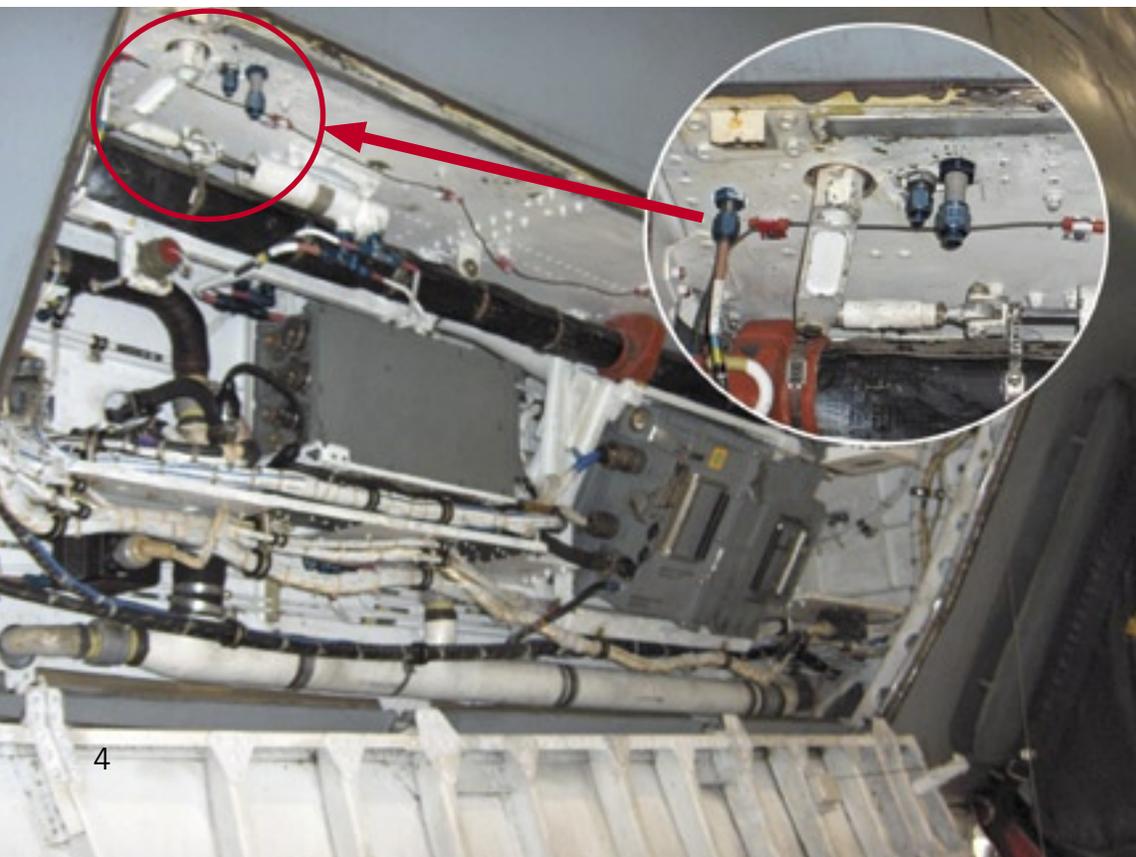
Naval Aviation Technical Training Unit (CNATTU).

The installation of the airspeed indicator went without any problems. After the installation was complete, we grabbed the handheld controller for the test set and the op-check manual. We started from step 5 in the op-check manual because the day shift already had completed the pre-op checks on the test set. I realize now that had I looked back three steps, I would have seen that the procedures specify using the adapter set and hooking up the test set hoses to the pitot and static probes. As it was, the operational check went without a hitch.

We then started to remove the hoses from the drain lines in the cheek panel. While doing this, I noticed the caps that cover the drain lines were missing. I looked inside the top of the TTU-405 case, the backpack for the hoses, and approximately 18 inches around the drain lines, but I couldn’t find them. I assumed that the day check must have left them in the shop. As we were walking back to the hangar, I asked an airman heading out to the aircraft to grab the drain caps from the shop and to install them.

After we got back to the shop, I took a smoke break, used the head, and took about a 15-minute phone call from my wife. You can guess what happened. The airman, who had been asked to install the caps, didn’t do the job, and I completely forgot about it. We signed off the MAF and didn’t think anything else of it until the jet tried to take off the next day.

On the takeoff roll down the runway, the aircraft had zero airspeed because the drain caps had not been installed. The



missing drain caps were found wedged inside the door in the same cheek panel where we had worked.

Three major mistakes occurred: We had deviated from the book, had become preoccupied after finishing a job and forgot the task at hand, and had failed to get a thorough passdown, both oral and written, between the shifts.

You may ask, "What's the big deal?" Well, had this mistake occurred on the ship and not at NAS Whidbey Island, I could have written an entirely different story. According to the NATOPS manual, after a cat-shot with zero indicated airspeed and altitude, the first step is to eject!

In other words, my mistake could have cost four aircrew lives. If they didn't or couldn't eject, how could we have explained that error to a spouse or children? How would you say, "I'm sorry I killed your husband, wife,

mommy or daddy, because I simply forgot?" I know I couldn't.

I hope every maintainer for any type aircraft will think about my mistake before doing any aircraft maintenance. I now carry around a little green wheel book to write down everything I do during the day and the things I still need to do.

I learned an important lesson, especially about maintenance practices that widely become used and accepted. Just because a procedure is used throughout a squadron or in an aircraft community doesn't make it right. Please read your pubs, and do all the maintenance and QA procedures by the book. It's the only way to make sure something like my mistake doesn't happen to you. ✈️

Petty Officer Thurston works in the AE shop at VAQ-131.

Maintenance officer comment: Where was QA in this process?

Missing Tools Can Happen to Anyone

By AE1 Daniel Evans

Throughout my naval career, I've sat through numerous briefings, read dozens of articles, and personally reprimanded a few of my own troops about tool control. I always have prided myself on never losing a tool. So you can imagine my horror when it happened to me.

I was new to the squadron and anxious to prove myself. I always had worked on fixed-wing aircraft, so helicopters gave me a new, challenging learning experience.

As usual, the flight schedule was full, and we were working to keep aircraft mission capable. I was working with two other petty officers, another first class and a second class. We were flight-line troubleshooters and were called out to aircraft 555 to work on numerous pre-flight discrepancies. We found a problem with the auxiliary power plant, and, not wanting to lose the mission, we had the pilot shut down the helo so we could rush to fix the problem. We climbed on top of the aircraft and quickly went to work removing the APP compartment cowling. We spotted some loose electrical connections, which was an easy fix. Within 10 minutes, the APP was repaired and the helo ready to restart.

We checked our tools and headed inside to sign off the paperwork. In the meantime, 555 took off, and we thought everything was OK. A short time later, the second class on my crew was called out to another

aircraft. While checking his tool pouch, he saw that an adjustable wrench was missing.

My first reaction was disbelief. Even with three people looking at the tool pouch, we still had lost a tool. I immediately had everyone search their pockets, work areas, and other tool pouches. The tool couldn't be found. We then notified maintenance control, started a missing-tool report, and had the aircraft recalled.

When 555 got back, we opened the APP compartment, and, sure enough, the tool was right where we had left it.

I was angry with myself and couldn't believe I had let this happen. I am happy that we were fortunate to get the aircraft and crew back safely. Things could have been much worse. This event was a powerful reminder of how important it is to be ever vigilant about tool control. ✈️

Petty Officer Evans works at HM-14.

