stand that disaster is just a spark or zero oxygen breath away when working in open fuel cells. If LEL checks are performed without a gas-free certification, they should be logged on a MAF or in the workcenter's passdown log. In reality, type aircraft wings should ensure that all squadrons under their cognizance are performing and documenting LEL checks in the same manner. The best way to accomplish this task is through wing-directed local command procedures, using the NA-01-1A-35, and following recommendations issued by an industrial hygienist.

If personnel don't use good judgment and follow guidelines, they can die from inhaling gas fumes or in an explosion or fire caused by a tiny spark. Five personnel lost their lives in an explosion while performing fuel-cell maintenance on an E-2C. They did not perform LEL checks, and a simple spark from an unauthorized maintenance light killed them in an instant. We need to protect our folks to prevent the same action from occurring again. To be safe, then, why not issue a gas-free certification? The danger still exists, arms in or head in; you're just as dead by breathing toxic fumes as you are from an explosion.

Chief Hofstad is a maintenance analyst at the Naval Safety Center.

Class C Mishap Summary

By ADCS(AW/SW) Gary Dennis

From Aug. 04, 2004, to Nov. 30, 2004, the Navy had 37 Class C's that involved 39 aircraft. The damage total was $1,772,133.

• Following flight operations, an EA-6B Prowler was spotted on the fantail and later was moved to a position aft of the No. 4 wire. The nose of the EA-6B was facing aft, with the station one pod adjacent to the "junkyard" on the starboard side of the ship. Between the hours of 2300 and 0700, maintenance was performed on the No. 4 wire. This maintenance included using two A/S32A-31A (stubby tow tractors). During the maintenance evolution, a squadron maintainer observed a stubby tractor drive between the aircraft station one pod and the "junkyard," going toward the bow.

Prior to flight ops the next morning, the aircraft was to be moved to the No. 2 elevator. As the aircraft was being moved, a maintainer noticed damage along the lower outboard side of the station one pod radome. Personnel visually inspected the area around the damage and found multiple pieces of paint chips and composite material. Damage to the radome was measured at 40.5 inches from the flight deck to the impact area.

Further investigation was conducted on various pieces of SE on the flight deck. Inspection of SE tractors showed that the aft portion of the top deck of one tractor measured at 40.5 inches. Further inspection of the SE found two stubby tractors parked nose to tail in the "junkyard." The outboard stubby tow tractor, closest to the landing area, had a significant rub mark and pieces of composite material in a small cubbyhole on the aft port side.

Failure to properly supervise the arresting gear maintenance crew led to this mishap, at a cost of $23,464.

• A crew chief fell from a UH-1 while descending from a hover to a confined-area landing (CAL). The crew chief sustained extensive injuries, resulting in more than five lost workdays. Two crew chiefs under instruction (CCUI) were on the flight that day. A five-man bench seat was part of the aircraft's installed equipment at that time and was inspected IAW daily card 1.9 before flight.

The helicopter took off for NVG CAL work at CAL site No. 5. CAL site No. 5 is a published site, with a very large, relatively flat, unprepared surface and negligible obstructions on three sides. During the fifth CAL evolution, landing checks were performed, and the crew chief and both CCUIs replied, "Set in back." A normal final approach profile was flown, and, while restrained in lap belts, both CCUIs performed clearing calls on each side of the aircraft at both 50 feet AGL and 25 feet AGL. At 15 feet AGL, the pilot shallowed out his final approach, and more clearing calls were made by both CCUIs. While making clearance calls, in a 15-foot-AGL, near-zero airspeed hover, one of the CCUIs fell from the right side of the aircraft and hit the ground. The pilot landed the aircraft, and the crew chief was recovered, then was flown three miles to the base-hospital landing pad.

Investigation results revealed the current lap-belt anchor latches possess a movable arm that is constructed of thin, folded metal around a spring that keeps the movable latch arm in the closed position. This thin, folded metal arm is easily pinched and deformed in such a manner that it renders the spring useless, and the movable arm no longer is held in the closed position. Testing shows that nearly all of the lap belts in this squadron can have one or both of the anchor-latch springs defeated in this manner with thumb pressure on the movable arms.

The cause of this mishap was equipment failure at a cost of only $2,330, but a shipmate was injured seriously.

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