

# Getting the Drop on a Shipmate

By AO1(AW) Allen Davis

After an accelerated COMPTUEX and JTFEX, our squadron was on a 96-hour tether for deployment. My crew was wet and tired from the hectic pace on a rainy day. Our task was to check every aircraft rack for slave pistons, and this job involved the release of many



drop-tanks. The number of tanks we had to drop should have brought up my guard, but it didn't.

With only two fuel tanks left to check, potential disaster struck, and I was in charge of the effort. The procedure required one of my crew members to pop the fuel-tank cap, and then I would check the level. After checking numerous tanks on many aircraft, I saw the cap on 406 had been removed. After a few minutes spent walking around, I asked another crew member if he had checked the fuel level. I didn't get a response as

he walked away, but I saw that the fuel-tank cap had been replaced. I assumed, which is the cardinal sin in our business, that the tank had been checked. After completing the fuel-tank checks, we waited about 20 minutes to lower the drop-tank.

I called out, "Ready Nose? Ready tail? Coming down!" And it did! Before I could react, one of my crew members was on the ground in pain. "Oh no!" I thought, before running to help. We pulled him to safety but feared his leg was broken. The force of the full tank severely sprained and dislocated his foot.

This incident gave me a lot to think about. How could I have avoided it? How could I have let down my team and squadron? The "what ifs" in this incident are haunting. I could have taken an entire load team away from an already undermanned workcenter. That impact would have affected the entire squadron. Heck, I still ended up taking two qualified personnel away from the workcenter because I chose not to use a simple ORM review.

Had I identified the hazards, the first step of ORM, the rain and fatigue would have rung a bell. I could have identified and assessed those risks (steps one and two) and could have made a risk-based decision, waiting until the aircraft was back in the hangar to do the work (steps three and four—make risk decisions and implement controls). I should have done better and should have taken the possible dangers into account.

I learned the hard way. I hope, once and for all, people who read my story will work to prevent another incident. Risk is inherent in many of our jobs. Use ORM, brief your work teams, analyze the risks of even the simplest job, and discuss mishap-reduction schemes with team members. A few moments spent to delineate a plan will save a ton of time and pain after a mishap. 

Petty Officer Davis wrote this story while assigned to the ordnance shop at VFA-94.