

The Rest of the Story



By Cdr. Don Braswell

A safety incident report details the sequence of events for a ramp strike a Cat I nugget had the second night of CQ. But, several events that occurred after the ramp strike also should be mentioned. A lot of good, quick decisions were made that prevented further mishaps.

Before the nugget was clear of the ramp, the LSOs, AirOps, and the tower asked for a dirty bingo for the FA-18 to North Island. The man with the answer to their question that night was a fleet-experienced lieutenant in CATCC. He immediately broke out the PCL and helped the nugget get on the correct profile. The lieutenant did his job by the book. CATCC had more help available than the lieutenant needed, but no one jumped in—no one needed to. The lieutenant figured the nugget barely had enough fuel to fly to the field, with almost no reserve for a night or an instrument approach.

Immediately after getting the nugget on the correct flight profile, he checked the landing procedures for suspected bad landing gear. Again, he went by the book.

Fortunately, another experienced lieutenant also was airborne, joined on the damaged aircraft, and used his probe light to inspect the land-

ing gear. He correctly assessed the damage to the main landing gear. He and the lieutenant in CATCC then came to the right conclusions and gave the nugget his best chance at a safe field landing. The nugget landed with 1,000 pounds.

Back on the ship, the air boss had put the other nuggets into the delta pattern, while flight-deck personnel did a combat FOD walkdown. The walkdown results were bad: 40 to 50 small pieces of metal were all over the flight deck. All the turning jets on the deck were shut down, and the airborne jets were diverted. Because the primary divert had a fouled runway, the jets were sent to the secondary divert. CATCC did a great job of diverting these aircraft, full of nuggets, to an unfamiliar field in the middle of the night. End of story.

You may ask, “What’s the big deal?” There was none, but, sometimes when we read *Approach*, we forget how much we do right every day and how quickly we respond to emergencies. In this scenario, the right people in the right places made the right decisions. A misstep in any of the above procedures, and the SIR would have been a lot longer. It’s a tribute to the way we do business that this incident was almost a “routine” emergency. That’s the rest of the story. 🦅

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Photo by PHAN Janice Kreisler

