

# So Much for a Routine



By AMS2 Shawn Gray

It was a beautiful Florida morning, and I just had finished a three-day weekend. At the morning maintenance meeting, I was appointed move director for an aircraft going to the wash rack. The recent ops tempo had been high, and I was looking forward to a change of pace.

As the other members of the wash crew assembled, we reminisced about the long weekend, discussed current events, and talked at length about interest rates and refinancing. After eating breakfast, we reassembled at the aircraft. Everyone fell into place, and I quickly scanned the intended route. Satisfied that everything was clear, I signaled for the move to begin.

Shortly after making the first turn, we encountered our first obstacle. A large fire bottle seemed a little out of place, so I told the tug operator to move slightly off centerline to allow additional clearance. Every member of my team signaled clear, and we quickly positioned the aircraft back on centerline. A few minutes later, as we began to approach

A huddle around an aircraft never is a good sign.

the hangar, I noticed a forklift. It belonged to another squadron and had been moved out of the hangar. Unsure of the clearance, I directed the aircraft slowed to a snail's pace. I maintained my position near the nose of the aircraft and looked at my starboard wing walker to make sure

we were clear. I got a "thumbs up," and we moved on. I maintained a constant watch on the wing and my wing walker and was reassured the aircraft would clear the forklift. We proceeded with caution.

A blast from an air horn pierced the air, signaling the tug operator to stop immediately. When the aircraft came to rest, I walked over to the starboard wing walker and discussed how we would get around the forklift. To my disbelief, the wing already had struck the forklift, piercing the leading edge. The move was halted, and I notified maintenance control and the safety department.

I can imagine what many readers are thinking. I, too, am amazed at how this happened. So what went wrong? We did not do a pre-move brief. We were complacent. We knew each other very well and had done routine moves, like this one, many times in the past. In hindsight, a brief would have given us a much-needed focus after the long weekend. A quick brief also would have allowed me to learn what the safety department found after the mishap. Yes, hindsight is 20/20.

# Aircraft Move



## Mishap Reduction Opportunity

### Aircraft Towing or Taxi Incidents (Crunches) FY01 through FY03

These mishaps were preventable and offer a great chance for improvement in numbers and cost. In just three years, 39 crunches were reported (more might have gone unreported) for a staggering cost of \$6,766,461, (an average of \$173,499 per crunch) about the cost of an H-60. We had one Class A, seven Class B's, and 31 Class C's, resulting in the large dollar loss and three first-aid injuries. We can and must do better in this area. Plane captains, flight-deck and hangar-bay crewmen, and aircrew must work together to prevent these incidents that rob us of time, readiness, money, and Sailors.

### Incidents by type aircraft:

FA-18	19
F-14	8
P-3	2
S-3	2
H-53	2
E-2	2
H-60	1
AV-8B	1
C-2	1
EA-6B	1

The wing appears to clear the obstacles, but...

The starboard wing walker had been involved in an auto incident. While not seriously injured, the Sailor was given a 48-hour SIQ chit and seven days of light duty. During that period, he was restricted from prolonged standing and excessive walking. He also had been taking prescription painkillers. How could I not know about something this important?

Before this incident, I never had heard of groundcrew-coordination training (GCT). It is a maintenance adaptation of the crew resource management (CRM) program that our flight crews successfully use. As a result of the incident, our squadron arranged for a wing-assigned instructor to teach GCT and ORM to the maintenance department. That training helped me to realize that one person could have spoken up and might have broken the link in the chain of events leading up to this incident. I also realized several alternate routes could have been chosen to the wash rack, instead of the one with the obstacles. The GCT and ORM training was well received, but I wish it had occurred months earlier. Our routine move would have been just that. 

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A closer look shows why a move checklist might have helped.