

By Jon Natividad

Maintaining equipment should be more than just a check in the box for your next FASMO inspection. Failure to repair equipment has proven deadly after several Marine Corps mishaps. Two specific mishaps, mirror images of each other, illustrate this point.

While traveling down a steep grade on a blacktop road, the driver of an M813, 5-ton truck lost control. The truck veered into a ditch and subsequently rolled. The driver was thrown from the cab and suffered severe head injuries. During an inspection of the cab, investigators noticed the vehicle's brake pedal stuck to the floorboard. A limited technical inspection of the vehicle revealed that cotter and clevis pins were missing from the brake pedal—these pins connect the brake-pedal assembly to the clevis rod. The master cylinder on the vehicle recently had been replaced, which would involve disconnecting these brake-system components. There are three explanations for the missing cotter pin:

- The pin was reused and collapsed under pressure.
- The pin was not bent or secured in place.

• A nut and bolt were used in place of the cotter pin, and they vibrated loose.

Further compounding the problem, two studs were missing from the steering knuckle, which may have caused the 5-ton to roll. A WSEM alert published 10 years before this mishap by MARCORLOGBASES identified the problem as common and provided guidance to re-torque the studs to 155 to 200 pounds. The same WSEM alert was re-issued after the recent mishap to once again remind the fleet of the problem.

An eerily similar mishap occurred two years later; this time the 5-ton was loaded with 19 passengers. The truck was traveling down a paved road approaching a four-way intersection. Again, as the driver attempted to slow the truck, the brake pedal went to the floorboard and stuck. To avoid colliding with civilian traffic, the driver swerved off the road, crossed the shoulder, and veered into a ditch. The truck bounced out of the ditch, slammed into a parked truck, and turned onto its side. Momentum carried the 5-ton into a gas station. As it flattened one of the gas

pumps, the truck's fuel lines ruptured and ignited the surrounding area. Seventeen of the Marines were taken to hospitals by medevac.

Once again, an investigation revealed the master cylinder had been replaced, and maintenance personnel had failed to bend the cotter pin to lock it into place.

The similarities between these two mishaps are a lack of quality control and a failure to follow established maintenance procedures. The guidance in our equipment technical manuals is straightforward, and mechanics must follow it explicitly. A simple check by a QC NCO could have caught the missing or incorrectly installed cotter pins. ☘

