

We Had a Comm

By AM3(AW) Shaun Brown

shop was having another busy night—like every other one on this deployment. Maintenance control had tasked our shop to troubleshoot a nose-landing-gear discrepancy and to replace a leaky port rudder servo on Ram 302. This job wasn't too tough, and I didn't expect to face the problems ahead.

The aircraft was scheduled to go to the hangar bay for an op check of the nose-landing gear. I told my crew to remove the rudder-servo panels while the aircraft still was on the flight deck. Before they could do that job, the aircraft was moved to a jack spot in the hangar bay. After the aircraft was positioned in the hangar, one airframer continued to remove the partly fastened rudder-servo panels. In the meantime,

the rest of my crew began placing and seating the jacks.

The first technician had used a ladder to remove the rudder-servo panels, and my team removed the ladder from the safety boundary lines so the aircraft could be raised. We jacked it in a matter of minutes, had no problems, and called the AEs to help troubleshoot the gripe on the nose gear.

I did a safety walk-around of the aircraft to make sure the flight-control surfaces were clear before we applied hydraulic power. I checked to make sure the AE2 in the cockpit was ready and made one more safety check of the aircraft. I checked with the jenny operator, and he gave me a thumbs up. I didn't notice my rudder-servo guy had put back the ladder inside the safety boundaries and had continued to remove the panels. I walked just forward of the starboard wing, noticed a technician on top of the jet, and instructed him to move away from the



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rudder surfaces. I told him to move toward the front of the aircraft. I once again checked with the AE2 to make sure he was ready for hydraulic power and then signaled the jenny operator to supply 3,000 psi.

When hydraulic pressure was applied, the port horizontal stabilator shifted down, hit the ladder, and tore a five-inch hole in the leading edge of the stabilator. The ladder collapsed and fell to the deck.

What went wrong? How could it have been prevented? These questions always are asked after a mishap. Was operational risk management (ORM) discussed and applied before any maintenance task took place? Another good question—and the answer is evident.

We had a total breakdown in communication among the supervisor, the technician working on the rudder-servo leak, and with me. We did not discuss or apply ORM before or during any of the multiple maintenance actions. Our

supervisor was highly motivated, but we tried to do two tasks simultaneously and did not coordinate the job, leading to this mishap. Trying to complete two jobs at once caused the op-check crew to take shortcuts. We did not have enough people to put a safety observer at each horizontal stabilator—a required step before applying hydraulic power to an aircraft.

Had we used ORM, this mishap could have been prevented. A shop supervisor or a team leader must make sure every maintainer is thoroughly aware of the potential hazards of doing two jobs at a time. I should have made sure our maintenance instructions and safety precautions were followed. I allowed this job to begin without the right number of people, and I allowed a blind spot to develop on the port side of the aircraft. We all learned an important lesson, but I will live with my mistake for a long time. 

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