

# Aircraft 1, Headset 0

By LCdr. Terry Carroll, Leslie York, and Dale Glardon

In most aviation accidents, a number of contributing causes join together like links in a chain or holes in Swiss cheese and allow a mishap to happen. If we remove any link from that chain, an accident will not occur. Human error is the most common cause of any mishap, and this story is about an aircraft that ate a communications headset. You will see the many links that led to our mishap.

Two experienced maintenance technicians just had completed a late-night engine turn and found a communications headset was not working. When the run was completed, one of the maintainers put the headset and cord inside an intake screen and went to another aircraft to do another turn. This was their first mistake because they did not turn in the headset as a broken tool.

The turn operator already had inspected the aircraft and its intakes before the screens were installed. When the screens arrived, the technician and the turn operator installed them, causing mistake number two. The turn operator had failed to complete a pre-op inspection on the turn screens, which would have revealed the headset and cord. The technicians also failed to make sure the work area thoroughly was illuminated with mobile light carts—the third mistake.

Since the headset did not work, the turn took place with the ground technician standing on the boarding ladder so he could communicate with the cockpit. That maintainer noted in his statement that “they were going to be short turns.” This meant the technicians had failed to follow procedures for an aircraft ground turn and made mistake number four.

Turn procedures require a headset and a communication cord. Had the bad one been turned in as broken and a new one checked out, the maintainer would not have stood on the boarding ladder with a bad headset stuffed in the turn screen. The headset FODed the engine, and the damage cost \$265,913.69.

These type of mistakes and accidents do happen especially given the high operational tempo of naval aviation, but most errors are preventable. This case was no exception. Our maintainers were well-trained and experienced mechanics, but they got complacent.

We have to insist on strict compliance with procedures, to avoid lax attitudes, and to think in terms of doing the mission effectively. When we break the “safety chain,” accidents will follow, and, in our case, we proved that theory again. 

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A comm headset never should be carried in an intake screen. An engine will turn any object into “trash” and will damage it’s blades. Keep intakes free of any foreign objects.





Photo by PH3 John Taucher

# Feeding a Harrier

By LCpl. Benjamin Torkelson

**A**S a plane captain and flight-line CDI on the AV-8B Harrier. I remember a hot, humid and sunny June day in the North Arabian Sea on board USS *Wasp*. I was attached to HMM-261(REIN). The ship was taking on big swells, and the wind was gusting across the deck. Our jets launched on schedule and everything was going great, but it wouldn't stay that way.

About one hour later, we heard the jets fly into the break, announcing their return. I grabbed my cranial and float coat and headed to the flight deck for the recovery. My cranial had an internal communication system: a microphone, special ear cups, and a long cord to connect it to the aircraft. I tucked that cord into my float coat—like always—and went to work.

The flight deck is a dangerous place, but I have to admit I had become lax. We had followed the same

routine for almost three straight months at sea. I watched as the jets uneventfully recovered. Before the Harriers shut down, our normal practice is to wash out the intakes and engine with demineralized water to remove any salt spray. Once we had tied down Vegas 53, the ship's LSE turned over control of the aircraft to the PC, who then signaled the pilot for a compressor wash. He got a thumbs up, and we began the job. I came up to the intake on the port side with a hose in hand and began the task. Doing a good wash job requires the hose bearer to get close to the intake, but the ship was rocking, and the winds were gusting, so I got a lot closer than usual!

I could feel the engine pulling at my sleeves and tugging on my float coat. My comm cord suddenly was sucked out of my float coat and headed down the intake toward the spinning compressor. With one hand, I pushed away from the intake and tried to pull out the cord with the other. It was too late. I saw the end of the cord hit one of the blades and bounce around the intake. I turned around toward the PC and signaled to shut down the aircraft. I thought I had FODed the engine.

I didn't realize it immediately, but my entire cranial could have been pulled off my head, or worse, I might have followed it down the intake. I was shook up. A blueshirt, who had been standing forward of the intake, came up to me with a piece of the cord in his hand. He said it had shot out the intake and had hit him in the side. With the engine stopped, I looked at the intake to survey the damage.

Replacing a Harrier engine is a big job. We have to take off the wing, which requires a lot of man-hours. I got away with this one. No one was hurt, the damage was superficial, and the engine did not need to be replaced.

After this incident, my shop made a few changes to our PPE procedures. We wear the ICS cranial only when needed. We take our personal FOD checks more seriously before going near aircraft. We also watch how close we get to the intake, considering the wind and sea state. I now have an increased respect for the power of this aircraft and never will forget how close I came to feeding a Harrier. 

LCpl. Torkelson works in the power-line at HMM-261(REIN).