



Naval Safety Center

LESSONS LEARNED



19-17

MISHAPS AVERTED

“Rewards for good service should not be deferred a single day”

– Sun Tzu, The Art of War

We develop our safety lessons learned products primarily, but not exclusively, from single mishap investigation reports or by analyzing trends in a particular activity within a warfare community. However, on rare occasion, we receive a good news story about a potential mishap (or multiple mishaps) averted due to the awareness and actions of a single service member. Given our ultimate goal is to prevent mishaps, that scenario is a grand slam. The following examples demonstrate how individuals whose situational awareness and initiative averted potential future mishaps, and may have saved lives. If you have a good news story about someone in your command who saved the day, we desire to share it. Our contact information is included at the bottom of page two.

Under Pressure:

During routine diving safety assessments, a Naval Safety Center Chief with significant experience in cold-water diving identified an equipment mismatch that, if gone unnoticed, had the potential to cause serious problems for divers Navy-Marine Corps-wide. The Chief discovered that the cold-water diving first stage regulator was set at a pressure higher than the recommended operating pressure which, when operated in water temps below 38 degrees Fahrenheit, could cause the backup regulator to free flow and rapidly deplete the air in the tank (that can't be good). As a bonus, this diligent Chief also identified units using a wrong relief valve for cold-water diving, which would cause the same problem as the mismatching regulators. Because of this Chief's attention to detail, future mishaps were averted at several dive units and the word was passed to other Services that use similar gear. For more details, see the “Diving Safety Line,” Spring 2018 issue on our CAC enabled website.



One of these baskets is not like the others:

After numerous pilots in a squadron reported incidents in which the aerial refueling store (ARS) baskets did not seem to open correctly, a Sailor in one of the squadrons took it upon himself to attempt to figure it out. This motivated Sailor personally made the rounds on the carrier, visually inspecting all 12 of the ARS basket assemblies onboard the ship, including those belonging to another squadron. He discovered that one of the baskets was configured differently than all the others. Upon further investigation, it turned out that single basket was the ONLY one onboard the entire ship that was configured correctly. As a result of this one Sailor's initiative, the air wing was able to repair all the ARS pods to proper operation and prevent future mishaps. Furthermore, his discoveries opened the door to further investigation, identifying additional ARS problems across the Fleet. Well done! For the rest of the story, see the Lesson Learned (LL) 18-12 on our CAC enabled website.

MISHAPS AVERTED

Regular or Unleaded?

When a division of helicopters landed at a forward operating base to refuel, the fuel truck had “Jet-A” painted on the side of it, which was the fuel the aircraft required. An aircrewman from the helicopter inspected and accepted the fuel sample, and the fueling personnel and crew commenced refueling. During the refuel, a second aircrewman noted an unusual smell (gasoline does NOT smell like aviation fuel) and quickly stopped the fueling evolution. Upon investigation, they discovered the fuel truck contained regular gasoline, not the Jet-A that was posted on the truck. All the “Swiss cheese” holes in the proverbial mishap model were lining up, but the experience, situational awareness, and proactive response from that aircrewman broke the chain. Because he spoke up and stopped the evolution, he prevented the crew from becoming test pilots for discovering what happens when you try to run a jet engine on gasoline. At the very least, it would have likely ruined a perfectly good engine. At the worst, this could have been a mishap with the potential loss of aircraft and crew. Bravo Zulu to this aircrewman who saved valuable equipment and lives. Details are on our CAC enabled website in LL 18-02.



The not-so-Little Teapot

A Machinist's Mate 3rd Class was bringing up steam for the aircraft carrier's bow catapults after they were inactive for nearly two years. During a round of the spaces, she noticed the pressure had dropped and some steam was escaping one of the valves. Knowing this was not normal, she exited the space to report the issue and returned with others to investigate. Upon her return, the space was fogged up and she heard a sound like a suppressed gunshot. She immediately pulled a shipmate through a door to an adjacent space and called out for the other personnel (four sailors and four contractors) to evacuate. Subsequent investigation revealed a pin hole leak in a valve, which shot high pressure steam straight up to the overhead. This quick thinking Sailor saved herself and nine others from potential serious injury or worse. High pressure steam, at over 420 degrees Fahrenheit, shooting into a compartment is never a good thing, but this hero kept her cool and saved the day. Way to go!

TAKEAWAYS

1. Promote safety culture. Maintain a commitment to safety at all levels of the chain of command, and request a safety assessment from NAVSAFECEN. Units can also request a culture workshop, in which senior leaders will facilitate discussions and assess the key areas that make a safety conscious workplace.
2. Share your safety champion stories. While it is extremely important to glean lessons from mishaps to help prevent us from reliving them, we think it is equally (if not more) important to share stories of how an individual or team stopped a mishap before it could happen. So who is your unit safety champion? We want to hear about them. There's no required format, just forward your story to our lessons learned contact below.

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And remember, "Let's be careful out there"