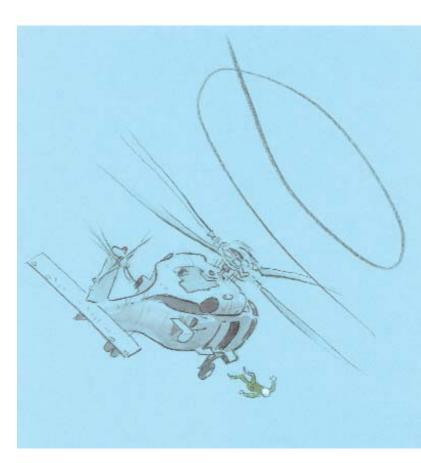


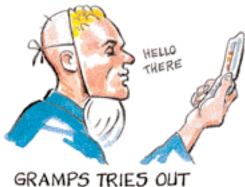
Illustrations by Ted Wilbur

Chopper Chain Reaction

A HAC, who had known marital stress but hadn't been through a human factors board, was paired with the detachment's weakest H2P and a warfare systems operator with a history of unstrapping without telling the pilots. The crew was scheduled for a functional check flight (FCF) on an SH-60B that had just had some work done on a gearbox and driveshaft. The FCF was complicated by a hydraulic leak during the ground turn, which was completed without a FOD check afterwards.

Because of schedule pressures due to a pending passenger transfer from another ship and routine meetings, the flight brief was cursory and did not include ORM or NATOPS items. The maintenance chief's brief to the crew was even shorter. As he had a tendency to do, the HAC skipped the preflight walkaround, electing instead to trust the H2P's assessment of the aircraft's condition. The helicopter lifted off and the pilot at the controls performed a normal hover check before





HIS NEW CAMERA PHONE ...

reporting "ops normal" and turning to the right and flying away to complete the check flight.

A few minutes later, the crew was performing tail rotor backup checks by moving the servo switch to the "backup" position, which caused the H-60 to lose control of the tail rotor. As the helicopter developed a rapid yaw, the warfare systems operator, who had once again unstrapped without telling the pilots, was ejected out the side door. The HAC, who had previously failed a HAC check flight because of demonstrated difficulty with reacting to tail rotor failures, elected to dump the nose in an attempt to fight the yaw with speed, forgetting that the aircraft was only at 1,000 feet. The aircraft hit the water

and was destroyed, killing both pilots. The warfare systems operator was never found.



Dang! If I was one of them Hollywood-type moviemakers and this was a script, I might be inclined to say it uses every cliché in the book: failing Naval Aviator, bad briefs, poor habit patterns, history of performance flaws, and on and on—including the ending. Only this wasn't a movie. This was real life . . . and death. Gramps is still waiting for the day when these stories stop telling themselves.

Field Trap Tragedy

During an F/A-18D squadron's combined arms exercise at a strategic expeditionary landing field, a two-plane launched on a practice JDAM delivery event. Before getting airborne, both crews had noted the Automatic Terminal Information System (ATIS) information regarding wind gusts up to 25 knots out of the southwest. During takeoff the pilots also compensated for significant crosswinds.

The practice bomb drop went as briefed. Approximately 10 minutes before landing the flight lead again checked ATIS, which was reporting gusts up to 40 knots. (The 90-degree crosswind limit for landing the F/A-18 is 30 knots.) The flight lead, who was flying as the wingman for the second half of the hop, didn't relay the information (he later said he didn't hear the wind warning). After holding for a time while another mission performed a simulated attack on the field, the section started an approach for a "battle break," which was supposed to be flown at 450 knots and 1,000 feet. The wing aircraft, now leading the section, actually came into the break at 488 knots and broke just past the approach end numbers.

Because of the excessive speed in the break, the first Hornet didn't reach gear speed until the 45-degree position. The pilot also fought an overshooting crosswind throughout the approach. He decided to fly fast on final in an attempt to minimize the effect the crosswinds were having on the jet, and wound up touching down 40 knots fast, and 2,000 feet long.

As the Hornet rolled out the pilot felt that the airplane was not decelerating normally, but when he advanced the throttles to take off again, he felt that the airplane wasn't accelerating. He aborted the go around attempt.

The pilot dropped the hook in time to take the long field arresting gear but the hook skipped over the wire. The jet continued off the runway and went over a berm, which caused the aircraft to pitch up violently. The pilot was certain the jet would come apart once it hit the ground again, so he initiated ejection.

Both aircrew ejected successfully. The pilot landed without incident, but the WSO was knocked unconscious and unable to release himself from his wind-filled chute. He was dragged for nearly a mile and finally came to rest in a deep LOX pit that caused severe blunt force injuries. He died later that evening.



HOT SEAT



Now Gramps' first question is: what was going on during the preflight walkaround? Did the crew not notice that the wind was honking—and out of a direction that should have made them think about crosswind limits? It's not all about technology, you know. Aviators need to take advantage of all the clues provided. As far as ATIS goes, of course it ain't as entertaining as Jack Benny on the wireless, but the smart ones give it a good listen, all the same.

It was obviously the wrong day to come smokin' into the break, too. Instead of focusing on the Sierra Hotel stuff, the crew should have worked on staying ahead of the airplane. And you all know how much good runway behind you is. Giving away 2,000 feet is seldom a good idea, and in this case, it had the worst kind of consequences for a shipmate.