

# GRAMPAW PETTIBONE

## Check That Tab

Upon being catapulted from a CVE, a TBM was seen to pull up into a very steep climb until, upon reaching 200 feet, it fell off into a spin and crashed, killing all three occupants. Full tail-heavy elevator tab setting was believed to have caused the accident.

► **COMMENT**—This is one of several very similar accidents in recent weeks. In view of this, it is seriously recommended that pilots make an extra check of the elevator tab setting before being catapulted.

## Give Your Engine Air

A squadron recently lost two SB2C airplanes at sea because of engine trouble. A few days later a third airplane had similar difficulty in flight consisting of severe loss of power and back-firing. This airplane, however, was able to remain in the air and return to base. Inspection revealed the trouble in this case to have been caused by a flapper door breaking loose and lodging so as to shut off the air supply to the carburetor. This flapper door failure may have been involved in all of these cases.

► **COMMENT**—A broken flapper door is not the only way that the air supply to the carburetor can be shut off. There is always the possibility of rags, birds, etc., fouling air ducts. These accidents bring out an important secondary use of the alternate air system which, it is believed, is not fully understood by all pilots.

In the case of the engine trouble noted above, the pilots took every measure possible to make certain that the engine was getting adequate fuel and that the ignition system was properly turned on. However, they apparently never thought of the fact that the engine also required air to operate. Had they suspected that the carburetor air supply was shut off, they should have known that they had an alternate source of air immediately available in the alternate air system. Had the pilots shifted to alternate air, it is probable that both of the crashed airplanes could have continued flight.

## Critical Weight and Balance

*Case 1.* An R50-5 went into a steep climb shortly after take-off, then squashed into the ground, out of control.

Investigation of this accident disclosed that the pilot (3,200 hours) had commenced his take-off without checking the load distribution. He may have done this before, but this time it was



fatal—eleven of the sixteen persons aboard were killed. A review of the loading showed the distribution to be such that the CG was aft of the maximum safe limit.

This case was referred to the Naval Aviator Disposition Board in accordance with paragraph 4 (j) of BuPers CL 62-44. The pilot was disenrolled from the naval service.

*Case 2.* Approximately 30 mins. after take-off, a heavily loaded PBO-1 was observed in a spin at 3,000 ft. Recovery was not effected and all aboard were killed in the ensuing crash.

In this case, weight and balance had been carefully checked prior to flight and the crew warned against shifting weight aft.

It was the opinion of the commanding officer that some of the crew, thinking perhaps the danger from loss of balance was over once the airplane was in normal flight, did move aft prior to the time the pilot lost control. A recheck of the loading showed the CG could have been moved beyond the maximum safe limit by the shifting aft of only two passengers.

► **COMMENT**—The latter case shows that whenever the CG is near the maximum safe limit, pilots must explain this carefully to

all aboard and personally retain absolute control of all shifting of weight until the CG is within safe limits.

Wartime conditions require service aircraft to be operated at maximum efficiency, which means operating right up to the loading limit. It is the last thousand pounds that enables military aircraft to reach vital enemy targets. It is also this last thousand pounds that becomes the most critical, as far as weight and balance is concerned. Since marginal stability may mean the difference between complete success or failure, it behooves all flying personnel to become thoroughly indoctrinated in this important subject and to exercise constant vigilance on weight and balance control.

See Technical Order 97-44.

## Big-Hearted To A Fault

We got dizzy, too, just reading about this belly landing:

"Flying wing on Ensign A, I broke off for my approach; Ensign A took a wave-off so I proceeded to land. When approximately 50 feet off the deck in my final approach, Ensign A called on his radio stating his wheel indicators showed wheels 'not down.' I took a wave-off, joined up on Ensign A and told him his wheels were down. I started another approach, wheels down, when Ensign A asked for me to check once more. I raised wheels and joined on Ensign A. Again I told him his wheels were down as far as I knew. Again I started my approach, which was very long because of an SNB landing before me. At an estimated 20 feet, in the full stall position, two red Very lights went off. Before I had advanced my throttle I hit the runway."

## A Commanding Officer Reports

"... It was a fighter sweep and all we know is what we have written to his family, that he just did not come back when it was all over. No one saw anything happen to him. It was the same thing in the case of the other two pilots we lost. We have absolutely no information on any of them.

"It's the old story—stick together; if not, suffer the consequences. All our previous warnings about what would happen to them if they didn't stick together, were of no avail. That's the queer thing about young pilots—they have to get a shock like this before they are convinced. Only these three didn't live to profit by their mistakes."



'Thumbs Up! Start Engines!' Taxi signalman aboard carrier directs the *Hellcat* pilot as chockman watches closely. Correct deck signals are necessary to keep operations moving



## GRAMPAW'S SAFETY QUIZ



All aviators should know the answers to these questions. In the air, the penalty for not knowing may prove fatal. If you miss an answer on the ground, penalize yourself by looking up the reference.

1. If you were flying as wingman in reduced visibility and you suddenly felt as though you were in some unusual altitude, what should you do?
2. Following an unusually hard landing, what precaution should the pilot take?
3. Do regulations make the wearing of shoulder harness mandatory?
4. If you were in position to take off and you received a red light from the tower, what should you do?
5. What are the first three things you should do to regain fuel suction if a tank is run dry in flight?

Answers on Page 40

### New Air/Sea Rescue Form

In response to demands from the fleet for a simplified, yet all-inclusive reporting of air/sea rescue operations, a new form (NavAer 1941) has been prepared and is now being distributed to the service. This new air/sea rescue form attempts to obtain more information, which will be the basis for initiation of improvements aiding both the crash survivors and rescue agencies, without overburdening the air combat intelligence officer who fills it out. The new blank replaces Form S52.

The ACI officer's task is made easier in that he may check the proper boxes in reporting ditchings and rescues which are more or less routine and yet the new form obtains sufficient information for analysis of causes for delays or failures. These studies will be made both by the chain of command and safety officers of the Navy Department in Washington.

In order to expedite corrective action, one copy of the form will be sent to either ComAirPac or ComAirLant, depending on the theater of operations.

### Ditching Reminders

An SBD was forced to land in the open sea after engine failure. Weather and sea conditions at the time consisted of a negligible surface wind and a moderate ground swell. The pilot elected to land into the wind and

across the swells. His plane hit a swell head on and came to an abrupt stop. The gunner got out unhurt, but the pilot was evidently severely injured. He gave one yell at the moment of impact and did not get clear before the plane sank.

Although there was insufficient evidence to determine exactly what happened in this case, reports of similar ditchings have disclosed several errors which may have been involved. The reporting officers accordingly recommended that pilots be reminded of the following important points when ditching:

1. Land parallel and along the top of moderate or heavy ground swells. (Comment: Where very strong winds are blowing, aircraft should be ditched into the wind.)
2. Remember that the sea is usually much rougher than it appears from the air.
3. Be sure that the cockpit enclosure is not only fully open, but that it is *locked open*—so that it will not jam shut upon impact.
4. Be certain that shoulder straps are properly adjusted and fastened. As an extra precaution, put your left arm up in front of your face just as plane contacts the water.

### A Pointed Lesson

A two-plane section of SBD's on routine inshore patrol became separated when they entered a bad weather area. One returned safely to base, but the other became lost.

The return of only one plane to base was the first indication received that the airplanes were separated. Contact with the lost plane was immediately established, but the first RDF bearing sent out was a reciprocal. Before homing could be completed, the lost plane radioed that he was out of gas and was making a forced landing. Thorough and prolonged search of the area failed to reveal any trace of the plane or its occupants.

In reporting the case, the commanding officer said:

"The lessons to be drawn from this incident are few, and they are not new, but they are very pointed. It is desired

### They Neglected One Item

The mech failed to remove the rudder batten.

The pilot neglected to check his movable controls.

The airplane swerved on take-off and crashed into a floodlight platform because the rudder was locked.

The pilot was killed.

to emphasize the following points:

"1. The first mistake was in the pilot needlessly getting lost, that is, by flying in instrument conditions when there was no necessity for it. In this case, two lives were sacrificed, and two others jeopardized, for no worthwhile reason whatsoever.

"2. All pilots on all flights should navigate by every means at their disposal. The attempt by a pilot to avoid doing his own navigation or to rely on mechanical navigational devices to the utter exclusion of his seaman's eye, is inevitably bound to end fatally.

"3. Survival and ditching sense must be driven home 24 hours a day, every day, so that the routine can be followed instantly when a pilot gets into trouble. Such items as jettisoning bombs to conserve fuel and turning on emergency IFF gear should be second nature, not things to do at the last minute, or when it is too late. Apparently only by ceaseless repetition can this be ingrained so that it is not forgotten in the excitement and stress of a tight spot.

"4. In cases of doubtful bearings, the standard practice of having the plane fly a course 90° from the original course for five minutes, and then taking another bearing, has proved itself time and again, and would obviate any possibility of a reciprocal bearing."

 *Gram paw Pettibone says:*  
Amen and Hallelujah!

Amen, Skipper, to your all-out attitude on flight safety and to each of the points you so ably stress. Start growing whiskers, son, because this tabs you as my relief—Hallelujah!

### An Almost Accident

A possible serious accident was narrowly averted in a PBV-5A recently. Someone had inadvertently inserted the gun sight male plug into the bomb release firing receptacle. This would have completed the circuit for dropping the bombs when the manual switch in the bow control panel was thrown to the "On" position. Fortunately the "setup" was caught before this occurred.

▶ *Comment*—In the bow of the PBV there are two electrical receptacles; one for the bomb release firing key and the other for the gun sight or gun camera. Both receptacles are of the same type, but each is plainly marked to identify it.

All PBV crews should be warned against the danger of making a mistake such as was made in this case. The serious results which can occur from negligence in this regard are readily apparent.

An additional guard against the occurrence of such an accident on the ground is provided by inserting latching (safety) pins in the bomb racks—to be pulled by the ordnanceman just before the airplane is launched. See ComAirLant 25-TB-44.