GRAMPAW PETTIBONE

How It's Done

After shooting down nine Jap planes on one flight, the Navy's leading ace had only two rounds of ammunition and six gallons of gas remaining when he returned to the carrier.

When asked how he managed to make his ammunition hold out, he replied, "Well, it looked like a long fight, so I nursed my ammunition. I waited until I'd get right on a Jap's tail; then I'd fire only short bursts."

When asked how he dared let his gas run so low, he answered, "I wasn't worried about my gas. I had drained that tank in flight a half-dozen times to make sure I had the readings on the gauge down pat."

Grampaw Pettibone says:
Not a bad day's work!

And don't get the idea that this was an accident. Results like this don't just happen; they are achieved only by thorough preparation. Think of the background of training, personal effort, self-discipline and intelligent attention to detail which went into making this record possible!

A word of warning to the inexperienced concerning the dangers involved in draining fuel tanks in flight. Before you try this, be sure that you have plenty of altitude, and that you know exactly how to regain suction. See Flight Safety Bulletins 7-44 and 25-44.

Faulty Procedure

One station recently had an epidemic of failures of hand crank gear box supports and pilot's distribution panels in FM-2 airplanes. Investigation disclosed they were caused by improper lowering of the gear by the pilots concerned. In order to obviate the necessity for cranking, pilots were releasing the handcrank and then overcoming the brake by pulling up or making a sharp turn. This allowed the gear to "run free" and caused the damage.

As a result of this investigation, the station issued an order that the landing gear would be lowered only when the plane was in normal flight.

Grampaw Pettibone says:
A sad commentary on this accident was the fact that most of the pilots interviewed were entirely unaware of the existence of F4F-FM Aircraft Bulletin dated 8 December 1944, subject: *Accidental Collapse of Landing Gear*. This bulletin warned of the troubles being experienced with the F4F-FM landing gear and directed that all pilots be given special instruction regarding its correct operation. How can you expect pilots to prevent accidents of this sort, if they don't get the word?

I know all about the plethora of TO's, TN's, bulletins, changes, et cetera and so on, but what are you going to do about it? Each one is issued to improve operating efficiency of aircraft and, what is more important, to save the lives of those who fly them. You can't just stop publishing this stuff and say, "Let 'em find out for themselves." If you did that, you would soon run out of aviators and planes.

How would you like to get a copy of all AAR's and RUDM's, like we used to do, and have to figure out everything for yourself? Now they all come in to the Department. The data you get represents the digested screening and analysis of the operational and accident experience of the entire service, prepared solely for your benefit—to try and help you avoid having similar troubles.

Granted some of this instructional material may not be too well prepared and some may be considered unnecessary; this still isn't any justification for damning all of it. It's up to operating units (as usual, the skipper holds the bag) to see that everybody concerned gets the word. No matter how much time and effort this takes, it saves a much larger number of man-hours which otherwise would have to be spent building new planes and repairing wrecks—not to mention the more important item of lives. *Knowledge is safety.*

Take-off Fiasco

A flight of six SB2C's taxied out to the take-off runway. Before the leader was ready for take-off, the tower called and changed the runway in use. The leader acknowledged and started for the new runway. Also at this time, five F6F's which were waiting to take off, began taxiing across the old runway toward the one newly designated.

In the meantime, the NO. 2 pilot in the SB2C group had aligned his plane on the old runway ready for take-off. He didn't receive the tower's signal on change of runway. When he saw his flight leader begin taxiing (to the new runway), he thought the leader was taking off. Approximately 25 seconds later, he started his take-off with full gun. He didn't see the planes taxiing in front of him until he got his tail up.

He sheared the starboard wing off his flight leader's plane, cut the vertical stabilizer off one of the F6F's and ended up in a sand dune with strike damage to his own plane. Miraculously, no one was injured!

This fiasco is an example of what can happen when standard operating procedures and safety precautions are ignored. The main errors made by this pilot were:

1. *Assumed* that this flight leader was taking off.
2. *Failed* to check the tower for a visual signal before taxiing into take-off position, as required by local flight rules.
3. *Neglected* to cock his plane around to make sure the runway was clear before he started his take-off.

Grampaw Pettibone says:
Under the circumstances, and not having gotten a clear signal from the tower or a take-off signalman, I feel that the last mistake was the worst because it showed the pilot lacked both common sense and a sense of responsibility.

An airplane is a lethal weapon; a weapon too dangerous to be entrusted to an irresponsible pilot. And dangerous not only to the pilot himself but, as in this case, to everyone else within range.

RESCUE AT SEA . . . *Two men from a destroyer assist the pilot of a U.S. Navy plane to safety after he was downed during action in the Western Pacific. The pilot, wearing a "Mae West", was spotted after ditching and rescue was not long in arriving. The crew members went over the side with a line to help the pilot aboard*

FM-2 Cockpit Confusion

After being given a wave-off during FCLP, an FM-2 pilot reached down to raise his flaps. Instead of turning the flap handle, however, he turned the fuel selector switch to the OFF position. Due to being at low altitude, there was insufficient time to regain suction when the engine cut out. Fortunately, the pilot was uninjured in the forced landing although the plane received major damage.

Grampaw Pettibone says:

Due to the difference in shape of these two controls, it is hard to find a good reason for making such as mistake. Proof that some pilots don't need a good reason, however, is evidenced by reports of four accidents from this cause during the past two months. This indicates the possibility of another epidemic such as that caused by the flaps-wheels confusion which was experienced in certain other aircraft.

The way to forestall such an epidemic is for all FM-2 pilots to be fully aware of the danger and then to spend enough time and effort to insure against making this error. It's worth the trouble—it may save your life!

Eternal Vigilance

Case 1. When his F4U slowed down in the landing turn, the pilot (700 hours) relaxed and turned his attention to other matters. Thereupon, the airplane went into a ground loop that wrecked the port wing. The following is taken from the CO's comments: "This pilot is an excellent flyer and a heads-up officer, but he neglected to *complete* this landing."

Case 2. Returning from a gunnery flight, an FM-2 *pilot* (1000 hours) failed to lower his wheels to the down-and-locked position. Although the pilot escaped unhurt, considerable damage to the airplane resulted. The pilot in this case had a novel alibi for his carelessness. He said it came about through his having flown too many hours without even having had a minor accident to remind him to remain alert.

Case 3. An SNJ pilot (500 hours) shifted fuel tanks to get ready for his landing. Instead of shifting to a full tank, however, he carelessly shifted his gas selector valve to the OFF position. This one careless slip cost him his life. When his engine quit, he hit the top of a tall tree, which caused him to strike the ground up-side-down.

▶ *Comment*—Over and over again, it is apparent that *carelessness* and *inattention* are solely responsible for a large percentage of our accidents. This lackadaisical attitude is especially pitiable in aviation where accidents all too often are fatal, and the personnel involved don't even get a chance to profit by their own mistakes.

Like *liberty*, the price of aviation safety is *Vigilance*—continued and unrelenting.

Bulininity

At an altitude of 40 feet immediately after takeoff, an F6F pilot (550 hours) attempted a slow roll during which the airplane flew into the ground.

The investigating board assigned "poor technique" as 50 percent of the underlying case of this accident.

Grampaw Pettibone says:

Poor technique, my aunt! This accident was due 100 percent to disobedience of orders. If pilots were expected to be able to do a slow roll on takeoff, they would be trained in that maneuver—and there would be no regulation against it. Then if they failed to make it all the way around, it might be considered poor technique.

Some pilots react to flight regulations like a bull does to a red rag. *Bulininity*, I call it—since asininity means "having the qualities of an ass."

Snap out of it! Stop and think a moment before lowering your head to charge into one of these regs. It isn't there just to keep you from having fun, as you may think, but to protect you. It was issued as the result of hundreds of accidents and millions of hours of flight experience. It represents hindsight and foresight and is based on the known limitations of personnel and equipment. Unfortunately, disciplinary action isn't the only penalty dished out for such violations; all too often it is *death*.

Taxi-Accident Eradicator

An harassed Trouble Board recently designed a simple gadget for eliminating taxi accidents. As will be seen from the following report, this "Anti-Doze Device" is based on the principle of the Grampaw Pettibone "Automatic Stimulator" reported in the May 15, 1945 issue of NANEWS and should be equally effective.

"There are four known methods of preventing taxi accidents:

1. Ground all pilots—obviously impracticable if the war is to be won.

2. Salvage dumb pilots. They should be good for two quarts of Grade "B" blood plasma, plus some fair ingredients for "K" rations for the K-9 contingent.

3. A grafting operation (simple for any Navy doctor)—grafting an ostrich's neck and an owl's head on each pilot, enabling him to see everything. The only conceivable objection would be the proclivity of the neck to hide its head at the approach of danger, thus vitiating the usefulness of the owl's head.

4. Install a special "Anti-Doze Device" in each pilot's cockpit. This consists of a simple wiring of the pilot's seat with attached spark coil. This coil is activated by the plane's radar. When the obstruction is picked up at, say 150 feet, the spark coil snaps into action, mildly shocking the pilot with 12 volts at one ampere. As the radar's pip shows the target increasingly near, the charge is stepped up correspondingly—to 24 volts, 10 amps when close aboard. By this time, the pilot is practically standing up, which enables him clearly to see the danger. At this voltage, even a dimwit will have enough turn-over to register the situation, and sufficient juice will flow through his reflexes to stimulate them into corrective action."

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 faced with the need of additional power during takeoff, should water injection be used?**
2. **When the propeller is pulled through by hand, in which direction should it be rotated?**
3. **Aircraft not provided with oxygen equipment may be flown to 16,000 feet; true or false?**
4. **In the event of a fire any place in the airplane during flight, the pilot's windows of multi-engine planes should *not* be opened; true or false?**
5. **If, while flying CFR, you encounter weather below that required for CFR, what should you do if not currently qualified to proceed on instruments?**

Answers on page 48

Pregnant With Danger

The First Pilot was bringing in a PV for a landing. The landing check-off had been completed. On the base leg, a C-46 was observed in take-off position on the runway. The First Pilot, unobserved by the Patrol Plane Commander, retracted his landing gear, intending to go around again. The C-46 cleared the runway, however, and the PPC motioned his co-pilot to continue with his landing.

The wheels-up horn was still blowing after the plane came to a stop (probably not heard because of ear phones with large muffs and noise on the plane's radio).

The Commanding Officer commented as follows on this case:

"This accident emphasizes the danger incident to disruption of the normal routine and sequence of events in landing or taking off. When an incident such as this occurs, pilots and co-pilots must recognize that it creates a situation pregnant with danger and must of necessity discard the normal routine and *completely recheck* the plane for landing.

"Radiomen have been instructed to check position of landing gear lever on base leg and final leg and inform pilot if wheels are up after turning on base leg."