

# GRAMPAW PETTIBONE

## Don't Kill Your Friends

Seven enlisted men were assembled on the hangar deck of the *USS Bon Homme Richard* waiting their turn at punching the bag when an unseen adversary in the form of a high explosive 20 mm. projectile crashed through the flight deck and sent all seven to the sick bay.

The shell came from the starboard 20 mm. gun on an F6F-5N which had landed a few minutes before. The pilot reported that three of his six guns had failed to fire and he believed that he had safetied all guns. Actually he had turned the gun charging handle to "Safe" and pushed the handle down, but he had not held it down long enough to safety the guns. The 20 mm. guns were held only by the sear.

An ordnanceman finished cleaning the .50 caliber guns on the port wing and was checking the port 20 mm. gun which had failed to fire. Another ordnanceman was busy checking the starboard 20 mm. gun which had fired.

The accident occurred when the ordnanceman working on the port guns called to a "passer-by" and asked him to "let the port guns go home" (i.e. allow the gun bolts to move into the forward position). The passer-by obligingly leaned into the cockpit, turned the port gun charger to "arm," turned on the master armament switch and the inboard gun switches and pressed the pickle. The 20 mm. guns slammed home and the starboard gun fired.

Neither the port ordnanceman or the "passer-by" had checked to see what was happening to the starboard guns. With the wings folded neither could see the other ordnanceman who was working on the starboard side, but had not yet unloaded the starboard 20 mm. gun.

The accident resulted from gross violations of safety orders and a lack of plain every-day common sense in handling weapons which are designed to kill.

## Bad Risk

The *Corsair* pictured here came out of a major overhaul a few weeks ago and is headed right back for another overhaul after just 11 hours in the air. Despite its peaceful appearance, it has



a center wing panel that is sprung and distorted, an engine that needs a major overhaul, and landing gear, flaps, and propeller that must be replaced.

It was last flown by a pilot who didn't heed regulations regarding the ferrying of naval aircraft. He continued a CFR flight into instrument weather, and was forced to climb out on top in order to avoid mountains in the area. Shortly after breaking out on top of the overcast, he experienced a partial engine failure, but was fortunate enough to get down through a break in the overcast and make a successful landing at an airfield nearby.

Instead of finding out what had caused the earlier engine trouble, the pilot gave the plane a ground run-up which appeared satisfactory, and took off again. On this second leg of his flight he flew through some scattered rain storms, and again found his engine cutting out just as he broke into clear weather. The engine would not supply sufficient power to maintain altitude, and it finally quit cold about 100 feet above the terrain. A successful wheels-up, flaps down, full stall, forced landing was made in a plowed field.

Subsequent investigation disclosed that there was no Dow Corning Number 4 on the terminals of the spark plug leads as directed in Engineering Bulletin 21-43. This condition permitted the terminals to collect moisture from the clouds and showers, thereby causing the engine to cut out.



*Grampaw Pettibone Says:*

Son, your life insurance company has a bad risk on its hands. First of all you violated written orders when you continued your ferry flight into instrument weather. Then when you got a reprieve after that first engine failure, did you call it a day and wait for the experts to find out WHY the engine cut out? Oh, no—you just barged right out and asked for trouble. I don't blame your Guardian Angel for going on strike after that boner.

## "Dear Grampaw Pettibone:

Out our way we started a little discussion which has now resulted in a terrific argument. In order to settle things we call on you to give your opinion on this problem.

1. Who is in charge of an aircraft in flight and responsible for an accident if one occurs:

a. Is it the Senior Aviator present? Why?

b. Is it the Senior Naval Aviator at the controls of the aircraft? Any light thrown our way may prevent further argument, but I doubt it.

Very respectfully,

MAJOR USMC



*Grampaw Pettibone Says:*

I'm glad you asked this question and I'm not surprised that it has caused some hot arguments. BuAer Manual states that any Navy plane taken into the air shall be commanded by a naval aviator, or naval aviation pilot designated by the commanding officer of the unit to which the aircraft is attached. Other naval aviators or naval aviation pilots and personnel on board the aircraft, whether or not senior to the person designated by the commanding officer, will be either in the status of the aircraft's crew or of passengers, and this status shall be clearly understood prior to the flight.

Here's the clincher: Art. 6-104—"The authority and responsibility of such commanding officer of an aircraft exist from the time he enters it preparatory to flight until he leaves it upon the completion of the flight, during which period the responsibility for the action of such aircraft and its crew and for any occurrence that results from the actions of the aircraft and its crew shall rest entirely upon him".

I think the above covers about 99% of the cases, but there are of course occasional instances where some common sense must be used in applying the rules. For example, in the case of two equally qualified pilots assigned a multi-engine plane for a two-hour bounce drill, where it is understood and authorized that each will practice landings and take-offs, a landing accident would be charged against the pilot controlling the aircraft at the time of the accident, even though the other pilot might have signed the clearance form for the flight, might be senior in rank, and riding in the co-pilot's seat.

Normally in the case of instructors and students, the instructor is clearly responsible for the safety of the flight . . . but what of the cadet who gets excited while taxiing in from a flight and jams on the brakes and stands an N2S on its nose. If

the error is clearly the cadet's and there was no corrective action that the instructor could have taken which would have prevented the accident, the accident is noted on the cards of both cadet and instructor and the pilot error is assigned to the cadet.

The important thing to remember is that when you sign the clearance form for a flight, or find your name on the daily flight schedule as pilot of a particular flight—you've got it, son, and you had better think twice before you get very far away from the controls—particularly on take-off and landing.

## Report Accidents Promptly

An accurately reported accident is a step towards a prevented accident. Time lag in accident reporting means deaths that could be avoided. Report all accidents promptly following the instructions outlined in Aircraft Circular Letter 119-45, and save lives.

## Fatal Mistake

The leader of a four plane division of SB2C's arrived at an outlying field and broke up his formation preparatory to a routine period of field carrier landing practice. Breaking off at an altitude of about 600 feet, parallel to the landing runway, the leader made a steep left turn with little or no power on. During this turn he lost altitude to commence his field carrier landing approach.

Upon nearing the approach altitude of about 100 feet the aircraft was still in a steep left turn and settling in a nose high attitude. Power was not re-applied and the plane spun to the left with about 120 degrees of the approach left to make. The plane hit the ground on the left wing and nose with a violent impact. The pilot was killed and the aircraft was demolished by impact and fire.



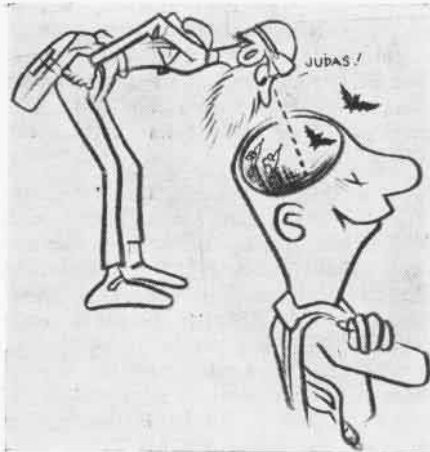
### Grampaw Pettibone Says:

This is only one of nine fatal spin and stall accidents in the SB2C during the past nine months. It is unique only in that the pilot who was killed in this accident had "read and initialed" Flight Safety Bulletin No. 21-44 shortly before the flight. This bulletin explains the increase of stalling speed in turns and associated dangers at low altitudes.

I'm afraid that you fellows sometimes initial safety bulletins and other important items on the "All Pilots" board without actually reading and digesting the material. It is hard to believe that this pilot really read and understood this Flight Safety Bulletin on the danger of steep low altitude turns, or paid close attention to the briefing which was given just before this flight. He violated almost every instruction that was given to him and lost his life as a result.

Keep sufficient airspeed in turns. If you get in a bad spot during a carrier or field carrier landing approach, don't be ashamed to take an early voluntary wave-off. Go around again—you'll live longer that way.

By the way, any squadron that is qualifying pilots in carrier landings or doing F.C.L.P. should arrange frequent showings of the excellent training film "Technique for Carrier Landings and Take-offs." This film may be ordered through the nearest Aviation Training Film Library and the order number is MN-5090.



## Lieutenant M. T. Head

An F4U pilot arrived at Los Angeles just before dark and circled the field calling for landing instructions. Receiving no answer, he attempted a landing without clearance from the tower and without field lighting. He selected a runway that was 5800 feet long, but over-shot and ran off the end of the runway where he hit a drainage ditch bordering the field. All blades on the propeller were bent forward a distance of twelve inches and the flaps and fairing were damaged.

The pilot had filed a clearance for another field but elected to continue on to Los Alamitos without refiling his clearance. NAS LOS ALAMITOS had no word of his expected arrival. Their airfield is closed from 1630 to 0800 unless prior notification is received of an expected flight.

**Bureau Comment**—Most pilot error accidents are caused by errors of technique, judgment, or just plain carelessness, but this one involves all three—plus disobedience of regulations.

Just to replace the three bent propeller blades on this F4U will cost close to \$2500. If inspection of the engine indicates possible damage due to sudden stoppage, it will cost an additional \$7000 for a major engine overhaul.

This accident would not have occurred if the pilot had used a little common sense and adhered to his flight clearance. He has

been ordered to appear before an informal board of investigation as a result of this accident.

## Close Out Flight Plans

**Case No. 1.** Pilot cleared for Asheville, N. C. from NAS ANACOSTIA. His clearance called for him to report his arrival at Asheville to the C.A.A. communications station at Spartanburg, as no facilities were available at Asheville for handling arrival and departure reports. Pilot violated C.A.R. 60.109 by failing to report his arrival to any C.A.A. communication station.

**Case No. 2** R4D pilot departed El Toro for Douglas, Arizona . . . failed to close out flight plan at Douglas and did not file a flight plan for the return trip. Pilot has been placed in probationary status by his commanding officer.

**Comment:** Both of these cases resulted in a great deal of unnecessary confusion, and plenty of embarrassment for the pilots concerned. Navy planes on cross-country flights are required to obtain proper clearances. When departing from a field where no communications facilities are available pilots may proceed only under contact flight rules and where practicable should fly to the nearest base or station where proper clearance may be obtained. Where this involves interference with the mission of the flight, radio clearance should be obtained from the nearest Navy clearance authority or A.A.F. Base Operations Office. After completing the flight it is the pilot's responsibility to see that his flight plan is properly closed out, so that search and rescue facilities will not be alerted on a false alarm.

Read Aviation Circular Letter 148-45 for complete details.

## Belly Landing Box Score

Here's the tally for last month on wheels up landings, an accident type that really runs up Grampaw's blood pressure:

No attempt to lower wheels.....	2
Inadequate attempt to lower wheels....	4
Raised wheels instead of flaps.....	2
Improper Maintenance (Plane Captain forgot cap on hydraulic reservoir	1
Miscellaneous material failures.....	5

Total 14



Here Lie the Bones  
Of Ensign Rube  
Who Forgot the Cover  
On the Pitot Tube.