

GRAMPAW PETTIBONE

No Hands or Nuthin'

Many an accident is caused by a pilot not getting the word, but here's one that is hard to tie. The plane—an F9F-2; the location—enroute to the combat zone; the pilot—a Lt. (jg) making his first catapult shot in any type of aircraft. Here's his description of what happened:

"On signal from the Catapult Officer, I performed full power turn-up and emergency system checks; checks were satisfactory. I put the throttle full-forward, and the fuel system selector switch in the take-off position. I gave the ready signal, put my head back against the rest, and took *my hands off stick and throttle as understood by prior briefing.*

"After the initial shock, I reached forward with my left hand against pressure to push throttle up as it had no friction lock, and I noticed a loss of power. I then realized that the plane was dropping and was pulling back on the stick as it hit the water in a nose down position. I saw the water hit the windshield. The next thing I knew the plane was on its back. I unbuckled my safety belt and pushed out easily, inflating my life jacket underwater. My helmet came off on impact. Parachute was attached and buckled on, not hampering exit or flotation. I swam away from the ship which left me to port as it made a gentle left turn, and was picked up in less than five minutes by a whaleboat."

This pilot's previous experience included normal flight training with carrier syllabus and carrier check-out in the F8F, but no catapult shots. He had also completed the regular TO-2 syllabus in the Jet Training Unit. During the three months just prior to the accident, he had accumulated close to 70 hours in the F9F including field carrier landing practice.

He had no previous accidents, and his progress through flight training and after joining the squadron had been satisfactory.

The briefing for the flight on which the accident occurred was given by the first two pilots in the air group to qualify aboard in jets and covered the usual catapulting instructions, technical orders, and catapult bulletins. The severity of the initial catapult "jolt" was discussed and may have been over-emphasized. In discussing the "jolt," it was



QUIT STALLING

*You may not think that this old bike
And your fast jets are much alike,
But don't forget that we both need
To keep above our stalling speed.*

mentioned that it was very difficult to hold the stick centered during the catapult run. This apparently led the pilot to believe that it would be wiser to leave his hand off the stick until airborne.



Grampaw Pettibone Says:

This chap had a first-class guardian angel, but he loaded him down with a few too many duties in this "hands-off" catapult shot.

The "jolt" in the catapulting of a jet is more severe than in a conventional fighter, because the jet must be accelerated to a speed of about 105 knots. Nevertheless, the pilot technique is just about the same. The stick should be held lightly during the firing with the elbow tucked into the stomach. In an F9F, I am told, that after the initial jolt, a very slight back pressure should be exerted on the stick to keep the plane in a flying attitude.

This pilot exhibited a healthy attitude after the accident. He was concerned over the loss of an extremely valuable plane, and he recognized his mistake. The Flight Surgeon found him qualified to resume flying within 24 hours, and he did so without incident.

When you crash on your very first attempt at any new maneuver, it takes courage to overcome your natural fear of trying it again. This pilot has since made a number of successful jet catapult shots.

All carrier pilots in training now receive a qualification catapult launch as part of the regular Training Command syllabus.

FREE ADVICE DEPARTMENT

Watch out for over-confidence—it kills several good pilots every month. Remember, few pilots are as good as they think they are, and none are as good as they thought they were.

Twenty Feet Too Low

A pilot is told to make a right hand approach, but turns left. The SNB crashes through the tree tops at the crest of a hill near the airport. Three are killed—one survives. Here's the story of the flight:

After a weather briefing for a cross-country flight, the pilot of an SNB elected to clear VFR to a point short of his intended destination. He understood that he would have to obtain additional clearance enroute to proceed.

Two hours later, he obtained an in-flight instrument clearance to his desired destination and estimated another two hours enroute. Position reports indicate that the flight proceeded normally at the assigned altitude.

About an hour after dark and right on his ETA, the pilot called the CAA communications center at his destination to report that he was in the vicinity of the station at 10,000 feet in a heavy snowstorm. He asked for let-down instructions and the latest local weather.

The pilot was informed that the ceiling was 1300 feet overcast, lower broken clouds, visibility six miles with rain and fog. The latest altimeter setting and the field elevation of 2100 feet was given. He was also advised that there is no official instrument letdown procedure for this airport, which has a VHF range station and a low frequency homer with power of less than 50 watts.

The communications center warned him of mountains near the airport and suggested that he make his let-down on the NE leg of the VHF range station, between the station and a point 4 miles out. Since the SNB-5 was not equipped to receive the VHF range on 108.3 mcs., it is assumed that the pilot carried out his let-down using the low frequency homer and printed headings of the VHF range.

The pilot was unable to establish communications with the tower when cleared to shift to low frequency and asked that the CAA communications center relay landing instructions.

At 4500 feet, the pilot reported that he could see lights through breaks in the clouds. A little later the tower controller saw the SNB as it passed over the field. The pilot was given a green light and again warned by VHF radio to make a *right hand approach* to avoid a 900-foot hill northeast of the airport.

The pilot acknowledged these instructions which were relayed by the CAA communications center. However, shortly thereafter he reported that he was VFR and making a descending *left turn*. He was again advised of the 900-foot hill between his position and the field, but repeated efforts to communicate with the plane by radio were unsuccessful.

The SNB had crashed into the trees at the top of the hill. Pilot, co-pilot, and one passenger were killed. The surviving passenger was riding on the starboard side behind the co-pilot and was wearing a set of earphones. He verified the fact that the pilot had been warned twice concerning the hills to the northeast of the airfield. After the crash which, he said, reminded him of a scene from "Slatery's Hurricane," he was momentarily knocked out. He must have regained consciousness within a matter of seconds and fought to get his safety belt open. Both arms were broken. He crawled a few feet from the plane before losing consciousness again. Rescuers reached him about a half hour later. The SNB burned for six hours.

Grampaw Pettibone Says:

What questions came into your mind after reading the bare facts of this tragic accident? I found myself asking, "How urgent was this flight? What circumstances put this SNB over an unfamiliar airport at night in a heavy snow storm? Why didn't the pilot land at his first destination? Why didn't he go to an alternate field when he discovered that there was no official instrument let-down procedure for this airport and that his plane was not equipped to receive the local range station?"

I couldn't help thinking that this accident was certainly one that wouldn't have happened to a pilot of average ability. Since the flight was not urgent, it seems to me that a pilot with just average confidence and ability would have listened to the unfavorable weather sequences, noted the approach of darkness, and decided to complete the trip when conditions were more favorable.

Therein lies the answer. The pilot in this accident *wasn't just average*. But his Commanding Officer tells the story very well in these words:

"It is an established fact that Lt. _____ was not only an outstanding Naval Aviator but also an excellent instrument pilot. Besides possessing a valid 'Special' instrument rating in SNB type aircraft, he was at the time of this accident the senior member of this All-Weather Squadron's instrument board. It also seems that Lt. _____ conducted the final stages of his attempted landing at the Airport contrary to instructions issued by tower personnel. These facts appear inconsistent with each other; and this accident, therefore, must serve as a monumental reminder to all naval aviators that, special qualifications, in themselves, do not relieve a pilot of the

continuing requirement to operate his airplane in such a prudent manner that at no time does he permit his familiarity to be tainted with contempt."



O.K. You Try One

This JRB-4 was being flown by a Reserve pilot who was making his first landing since his release to inactive duty in 1946. The accident board, however, charged the pilot error to the check pilot. He was riding in the left hand seat where he should have been able to correct any errors.

The landing was all right, and the plane rolled straight ahead for about 225 feet. When a swerve developed during the roll out, the check pilot waited too long to take over the controls. When he finally came to the rescue, he hit the brakes too hard. The JRB flipped over on its back and slid for 27 feet. Fortunately the pilots escaped with minor injuries.

Grampaw Pettibone Says:

This one boils down to—Who checks the check pilots?

A good check pilot is always ready to take-over at the first sign of trouble—not after things get out of control.

He'll Live, But

About ten minutes after take-off on a ferry flight, the pilot of an F6F-5 heard his engine surge, and noticed that his oil pressure was down to 50 lbs.

He was about 23 miles south of his point of departure and flying approximately 2500 feet above the terrain. The oil pressure dropped rapidly to zero and shortly afterwards the engine froze.

The pilot lowered the nose to maintain 100 knots, locked his shoulder harness, and informed the base from which he had departed that he was going to attempt an emergency landing at a small civilian airstrip about three miles away. He opened the canopy manually, and started a turn to approach the airport with about 1000 feet of altitude remaining.

It was apparent almost immediately that he would not have sufficient altitude to glide to the airstrip, so he selected a hay field and started for a wheels-up landing. Flaps were lowered, and all electrical switches and the fuel selector valve were turned off.

The pilot intended to make a fully stalled wheels-up landing, but when he

commenced his flare-out, he found that he had not maintained enough airspeed to get the nose up. The F6F-5 hit the ground in a rather steep nose-down attitude at approximately 60 knots. The canopy slammed shut, and the plane slid for about 150 feet before stopping.

Witnesses arriving at the scene of the accident helped the semi-conscious pilot out of the plane and phoned for an ambulance as the pilot had severe facial injuries.

The F6F was right-s.de-up. Although the initial impact had been hard enough to buckle the fuselage, the plane was not badly broken up.

Investigators noted that the seat structure and cockpit area were undamaged, and found that the shoulder harness lock and reel functioned normally. They were unable to discover any discrepancies in this equipment which might have led to the pilot's injuries. They could only surmise that he either placed the control in the unlocked position or failed to sit back far enough in the seat when locking his harness.

Grampaw Pettibone Says:

I don't often do this but I'm going to ask you to read the last paragraph of the Medical Officer's Report prepared while this pilot was still in a civilian hospital near the scene of the accident:

"Prognosis: This officer will survive. . . . The right eye has now been removed. Scarring of the face will be minimal. It will be necessary at a later date to reconstruct the septum of the nose, as it was totally destroyed except for the mucous membrane. As all the bones in the upper portion of the face were pulverized with fractures through the sinuses and probably the cribriform plate, it can be assumed that considerable future reconstruction may be necessary. It will be desirable after a period of about three weeks from this date to admit this man to a Naval hospital where there is a plastic surgeon."

That's a terrific price to pay for the two mistakes that were made in this emergency. The first was not being *positive* that his shoulder straps were locked and tight, the second was not maintaining enough flying speed to flare out in a normal landing attitude.

A lot of research has gone into the development of cockpit structures that won't go to pieces in severe accidents. Most Navy planes now have pilot's seats that will stay where they belong even in 40 G crashes. But neither of these factors will help you, if your body is free to go slamming around the cockpit.

In a good many emergencies you don't have time to do everything. If you don't have time to do anything else, sit back in your seat, lock your harness, and *keep flying speed*.

P.S. If you haven't seen Flight Safety Movie MN-4353M — "Accident Injury Prevention," ask your squadron Safety Officer to arrange a showing. It is available at the nearest Navy Film Library.