



GRAMPAW PETTIBONE

What's the Pitch?

The pilot of a P2V-3 took off in late afternoon on a four-hour flight to ferry his aircraft to NAS ATLANTA. Forecast weather enroute was a minimum ceiling of 400 feet, maximum cloud tops of 35,000 feet, thunderstorms with moderate to heavy turbulence, and a minimum flight visibility of one-half mile. The flight to Atlanta was uneventful although instrument weather was almost constant.

Arriving over the field after dark, the pilot was informed of an estimated ceiling of 1000 feet broken, 1500 feet overcast, three miles visibility with light to moderate rain. The pilot was cleared to runway 20 and given surface winds of 200 degrees at six to ten knots. He requested to land on runway 16 which is 3,980 feet long, 230 feet longer than runway 20. He was cleared to land on runway 16, but was not informed that a severe squall line had passed over the station one hour previously, leaving the runways covered with water.

A normal approach was made to a full-flap landing with the aircraft touching down at a point 1050 feet down the runway, leaving 2930 feet of usable runway for stopping. A quarter-inch sheet of water covered the upwind end of the runway. Immediately after touchdown, the pilot pumped his brakes intermittently for 1335 feet,



then locked them for the remainder of his toboggan ride. When it became evident that he was fast running out of runway, the pilot intentionally ground-looped his P2V to the right by applying full throttle to the port engine.

Skidding sideways, a million dollars worth of airplane slid off the end of the runway, plunged down a 35-foot embankment and crashed to a stop in the pine trees. The whole area was heavily saturated with fuel when one of the fuel cells burst. By extraordinary good luck, no fire ensued. The aircraft was a strike, but the five occupants escaped from the plane unhurt.

The pilot did not utilize reverse thrust during the rollout or make any attempt to initiate a wave-off. He had

3500 total flight hours; 280 in the P2V of which 37 hours had been flown in the last three months.



Gram paw Pettibone Says:

Gaspin' guppies! This one takes the cake. It's beyond me why an experienced pilot would choose to take off into instrument conditions and bore blindly through forecast thunderstorms in the first place. But landing after dark on a short, wet runway with no thought of using reverse pitch really stumps me. It's gross misjudgment and downright foolishness. All five occupants must have been thinking pure thoughts all day to come out of this one without a scratch.

Ferry movement of multi-engine dual control aircraft under IFR conditions is according to Hoyle (OPNAV INST 3710.6) when the point of departure and the destination are VFR (and destination will remain so for ETA plus one hour), but the intervening IFR conditions must be caused by a stable air mass with no icing. In my book, thunderstorms aren't stable. Besides, it just ain't smart to go charging through thunderheads unnecessarily.

This pilot had flown out of Atlanta for a year. He knew the length of the runways and the characteristic of the overrun areas to drop off abruptly into the toolies. He knew it was dark, and the fact that it was raining should have clued him that the runway would be wet, with resultant poor braking.

Following the accident, the NAS established a system of periodic briefing of tower operators to insure that pilots are advised of any unusual field or runway conditions.

In his statement, the pilot allowed as how if reverse pitch had been used immediately, the accident might have been prevented. He gave no inkling as to why he didn't give it a try.

The aircraft accident board figured there were additional ways of preventing the accident—like proceeding to his alternate, Robins AFB with its 10,600-foot runway, Dobbins AFB (at Atlanta) with its 10,000-foot strip, or Atlanta Municipal with its 5500 to 7860-foot runways. It's that simple.

Confound it! How about some reverse spin?



Dear Gramp:

While reading the July issue of the *Naval Aviation News*, I was particularly interested in your lead story about the fella with the accidentally inflated Mae West. That same problem has confronted me at about 30,000 feet.

The first time I really gave that Mae West a "fit" with a puncture tool that was taped to the instrument panel for just such an emergency. My radar operator (we were in an F3D-2 *Sky-knight*) happened to see me sitting there apparently beating my chest. Discovering the cause of my exertion, he promptly relieved the situation by simply removing the small CO₂ bottle from its holder. The air went out of the vest, and we continued our trip to Cherry Point.

I've asked quite a few of the pilots recently what their plan of action was to be if they inflated their Mae Wests by accident while in flight and *all* of them said they would puncture the vest. My personal experience is that punching a hole in that vest is no simple operation, and that it's much more expedient to simply remove the expended cartridge from its holder.

—MAJOR, USMC



Grampaw Pettibone Says:

The volume of response to that life vest piece makes it pretty evident that the problem needs a little more discussion. There are plenty of convictions, but they're not all right.

There's disagreement as to the number of compartments in a life vest as well as to the number and effect of oral inflation tubes. For emergency deflation, some say punch holes in it, some say don't. It reminds me of the three blind men with different opinions as to what an elephant would look like. All were partly right; it all depended on their individual angle of approach to the critter.

If you haven't worn a life jacket lately, you may just remember the old type that had two compartments, two oral inflation tubes and two CO₂ bottles. Because of their age, the odds are that most of these are no longer in service so there is no point in going into this phase.

A more common vest is the Mark II with one oral inflation tube for inflating the separate oral inflation chamber, and with two other compartments fillable only by CO₂ bottles.

The Mark IV or "integrated" life jacket is composed of two underarm cells, fillable either by bottle or tube.



It isn't necessary to know the Mark number to use your equipment effectively. If there are two oral inflation tubes, the vest should be deflatable by any of three ways: depressing the base of the tubes, underscrewing the caps to the CO₂ bottle compartments, or by stabbing. If there is only one oral inflation tube, it leads to a separate compartment and is useless for deflating a bottle-filled compartment.

Pilots disagree as to the accessibility of bottle container caps and oral inflation tubes when a life jacket is inadvertently inflated beneath shoulder straps, parachute harness and seat belt. But if the gent in the cockpit is familiar with his equipment, it shouldn't take him long to set things right.

As one of the letters pointed out, when a life jacket inflates, it's a simple matter to determine which CO₂ bottle has been expended—just feel which bottle is cold. Unscrewing that bottle container cap should permit the vest to deflate—unless some joker left a valve core in after testing the vest in the shop.

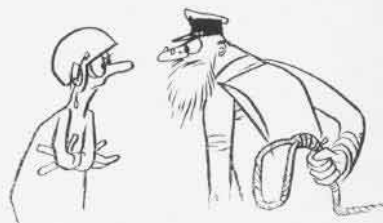
If the pilot is suffering acute discomfort or has great difficulty in breathing and can't readily depress the appropriate oral inflation tube or reach the offending CO₂ bottle receptacle cap, he should promptly grab and stab. He's the best judge of the urgency of the situation. Since life jackets are carried for their life-saving qualities, there's no point in unnecessarily punching holes in one that might be needed later in the flight. But under any circumstance, a frog-stabber's a handy thing to have along.

Given Enough Rope

A Ltjg. took off in a *Panther* on a scheduled gunnery tow flight. On reaching the range, he streamed his starboard banner which was canted. Releasing it, he attempted to stream the port banner. When it wouldn't stream, the pilot aborted the tow flight.

Enroute to base he "decided to inspect the area for possible 'ditching' points—places where the ground was smooth."

Approaching some railroad tracks, the pilot concluded the adjacent ground should be fairly level and went down to make an inspection. In the pilot's own words, "The air was bumpy and I felt a slight jar, but dismissed it as being of no consequence." Upon returning to base and taxiing to his parking spot, the line crewman told the pilot that he had a line trailing. The



pilot in turn told the O-in-C that perhaps something had happened, to which he received the reply, "We'll have to wait and see."

They soon got a line on the JG's activities. Unknown to the pilot, the port banner had streamed prior to his low pass on a freight train. The nylon towline swished through a very small community, scaring the wits out of the local folks. Then, kicking up a few stones, it broke the rear window in an occupied caboose of a moving freight train before catching on an automatic signal along the railroad track and leaving a 100-foot line as evidence—enough to hang the pilot!



Grampaw Pettibone Says:

The local press pictured the towline as slicing through town like a giant knife. The citizenry weren't the only ones to take an unkind view toward this type of shenanigans. A Field Naval Aviator Disposition Board also took a dim view of the situation.

While it frequently occurs that no personnel injury results and very little property damage is done, the fact can't be overlooked that flathatting not only endangers the life of the pilot and a good many others, but it frightens the pants off the populace.

Remember, it's not enough for the pilot to feel that nobody is actually endangered—but no person must *think* that he is. Damage to Navy public relations is something that just can't be marked on price tags.