



# GRAMPAW PETTIBONE

## Complacent

Although the weather was excellent for local VFR flying, supervisory personnel felt the operating area weather to be marginal for the F-8 pilot to fly his refresher flight and briefed him to remain in the local area, burn down to landing weight and practice ground controlled approaches.

After takeoff, the *Crusader* pilot climbed through a large hole in the broken cloud layer to 15,000 feet and, while practicing a stall, experienced generator failure. Feeling there would be no problem, he extended the ram air turbine (RAT). This action restored the UHF radio but not the *Tacan*. After checking the UHF homer and receiving no response, he requested a DF steer from the tower. (DF equipment had been removed from the tower, the pilot was informed.)

The lost soul contacted air traffic control center for radar assistance and explained his situation. In very short order, the controller informed the distressed pilot that his aircraft could not be identified by transponder *Ident* and requested him to turn south to establish radar identification. The pilot indicated he was having trouble reading the compass because of fogging in the cockpit and would remain on a northerly heading which he believed would take him toward the field. The center asked for a turn to 350°, observed an aircraft turn to that heading and advised the *Crusader* pilot that he was in radar contact eight miles from an Air Force base. The pilot acknowledged and noted he had 800 pounds of fuel remaining. A new heading was given, and the pilot responded. However, the radar target observed by the center continued on its original heading.

When informed of this discrepancy, the pilot stated he would want to evacuate his aircraft in short order. He was now under the overcast and by relating his visual sightings, assisted the center in locating him (positively) ten miles from his home base. Unfortunately, at this time the *Crusader* had



barely 100 pounds of fuel on board, so the pilot ejected.

He parachuted to the ground and returned to the NAS uninjured.



Grampaw Pettibone says:

Great balls of fire! How can so many people get so durned complacent at the same time.

One endorsement of the AAR has summed it up in proper fashion. Gramps can do nothing better than repeat parts of it: "Had any single individual done his as-

signed job properly during the train of events, this accident would never have occurred. I find the pilot culpable in that he did not use his available aircraft equipment—i.e. ADF, emergency IFF, and guard frequency and failed to call it a full-blown emergency early enough.

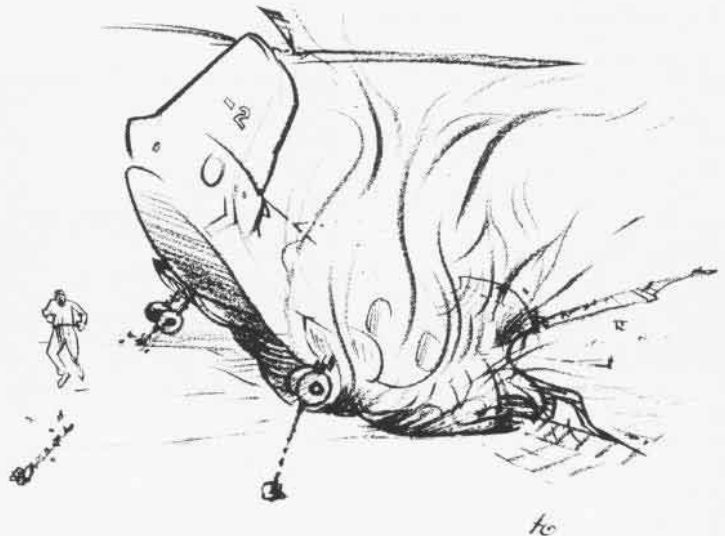
"The tower had a million-dollar GCA unit sitting on the field and didn't think to use it. ARTCC personnel, although confused by the pilot's failure to go to assigned headings, contributed their share by working other traffic at the same time, not recognizing a true emergency when they had one under their control."

## 50,000-Ton External Lift

The Marine CH-46A *Sea Knight* and a crew of four were scheduled for a conference lift to the deck of an LPH from a shore base. Passengers were four officers and five Marine enlisted's. The mid-morning flight to the ship went without incident. The crew and passengers had lunch on board, and the conference was held in the afternoon.

Preparations for the flight ashore began about 1600. Preflight, start, and rotor engagement proceeded in a normal manner.

The pilot and the helicopter direc-



tor then exchanged "thumbs up" signals. The pilot interpreted this signal to mean "cleared for takeoff." He attempted to lift; but the aircraft was secured to the flight deck with four tie-down chains. The port aft chain parted, and the craft pitched forward and rolled to the right into the catwalk.

The rotor blades disintegrated upon contact with the flight deck, and the large helicopter burst into flames. The passengers and crew quickly exited through the escape hatches and doors. Unfortunately, two of them suffered fatal burns.



**Grampaw Pettibone says:**

Thunderation! This'n really takes the cake. I hope there's a sobering lesson in this tragic mishap for all you eager tigers. The moral of this story is — or should be — pretty obvious. It is spelled N-A-T-O-P-S. It's said that Naval Gunnery Safety Precautions are written in blood; the same could be claimed for NATOPS. Every procedure has a darn good reason for being. It's my other middle name, y'know. Surely you've heard about P.S. Natops Pettibone.

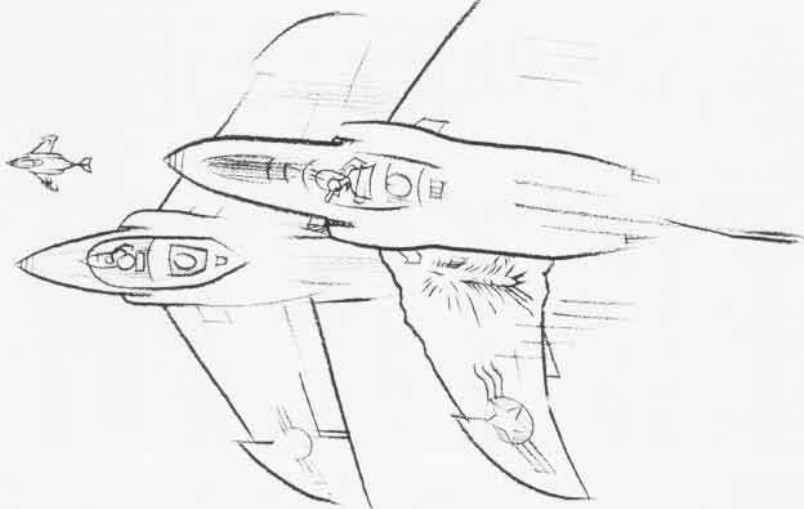
## Kiss of Death

It was the first conventional air-to-ground delivery flight of the F-4 replacement pilot (RP) training syllabus. Five *Phantoms*, piloted by RP's and carrying instructor Naval Flight Officers in the back seats, were to fly in the pattern. They will be referred to as Rockets 1 through 5. A sixth plane, Rocket 6, piloted by the instructor who briefed the flight, was to act as airborne observer.

After the brief, the planes launched routinely, joined up in left echelon, and proceeded to a nearby island target range. Each plane made two dry runs and two live runs on the target without incident. As Rocket 3 recovered from his second live run, he lost sight of Rocket 2. As he neared the roll-in point for this third run, he saw what he believed to be Rocket 2 in a dive. Taking proper interval he commenced his roll-in.

In actual fact, it was Rocket 1 that he had observed in the run and upon whom he had taken interval. The net result was that Rocket 3 had the belly of his aircraft toward Rocket 2 and was turning inside 2's run, in line, on a converging course. Rocket 6 orbiting overhead observed the two aircraft and transmitted "Simultaneous runs, abort, abort" on UHF.

*Oh Man! here we go!  
more wrinkle wing!*



Rocket 2 heard the transmission and looked around him. Not seeing any other aircraft, he continued his run. Rocket 3 didn't hear the call at all because his instructor RIO had selected radio over-ride on the interphone system to block out noise on UHF so he could converse with his pilot.

Rocket 3's instructor RIO sighted Rocket 2 at about 5,000 feet altitude during the dive. Rocket 2 was slightly stepped up and just a little distance off their port wing. A slight closing drift appeared to be carrying Rocket 2 over the top of Rocket 3.

The Rocket 3 instructor had been having some difficulty in making himself understood by his pilot. He therefore hesitated to advise him of the nearby aircraft for fear he would become alarmed and abort his run right into the other aircraft. He felt that if Rocket 2 made a normal run and pullout, and if they delayed their pullout, there would be no collision.

Rocket 6, observing the planes continuing in their runs, again called out "Abort, abort, pullout, heads up." By the time Rocket 2 heard this call, he had reached the release point and then started his normal pullout. He suddenly felt a definite jolt and saw Rocket 3 pass toward his 10 o'clock position from under his wing. The top of Rocket 3's vertical stabilizer had struck the port forward missile cavity and port inlet ramp of Rocket 2. The

two aircraft then separated without further contact.

Rocket 2 checked his instruments and controls. Finding them OK, he broadcast on UHF that there had been a mid-air. Rocket 3 was not aware of the collision until informed by his RIO. Both aircraft were checked over by Rocket 6 and returned to home base without difficulty.



**Grampaw Pettibone says:**

Sput! Sput! Kee-ri-manentics! That RIO was darn near as informational as the Sphinx. How he could just sit there and let the situation develop without saying anything is beyond me. Admittedly, he had little rapport with the pilot on the front seat, but he sure should'a had some faith in the pilot's ability to react to a hazardous situation.

Danged if I know which kinda mid-air is worse, two aircraft in the same formation or two unrelated birds. Either way, it's the Kiss of Death! — like arguin' between the electric chair and the firing squad.

They say two heads are better'n one, but too many cooks also spoil the broth. In this case, a lot of heads couldn't save the day.

## A Word to the Wise

Safety is achieved, not by luck, but by planning. Unfortunately, too many safety adjuncts have evolved through the application of *hindsight* rather than *foresight*. The philosophy underlying an effective safety program should therefore be the philosophy of prevention by positive measures, rather than the passive philosophy of waiting for the accident to dictate the cure (from ComFAIR Kleflavik Instruction 3750.2C).