



GRAMPAW PETTIBONE

Bum Steer

The first tour lieutenant joined his reconnaissance attack squadron which was deployed aboard the CVA in the forward area. During his first month on board he accumulated seven landings in the RA-5C *Vigilante* while becoming familiar with the routine of deployed carrier ops.

His first night recovery was scheduled as a "pinky"; however, conditions didn't turn out that way. It was a night navigation mission with a day launch and a night recovery. The two divert fields were covered carefully in the prelaunch briefing, and the mission was flown without incident, except that the radar attack navigator lost his radar presentation on the way out.

A Tacan penetration was commenced to the carrier deck some 40 minutes past sunset. Although the lieutenant's passes were relatively steady and not at all hairy, he succeeded in boltering four times and was subsequently diverted to the #2 alternate airfield given by departure control at 110 degrees, 220 miles. The duty tanker, a KA-3 *Skywarrior*, was assigned as escort and, after rendezvous, the *Vigilante* took on 2,000 lbs. of fuel. Upon completion of inflight refueling and at the request of departure control, the tanker turned back toward the ship. The pilot informed the A-5 that the divert field now bore 088 degrees at 88 miles. Within a minute or so, the *Vigilante's* lieutenant radar attack navigator (RAN) advised that he couldn't receive the field's Tacan station, so the A-3 turned back to rendezvous. A cloud layer soon separated the two airplanes, and they were never able to get together again.

The RA-5 pilot took up a heading of 090 degrees based on the tanker's steer and, upon reaching his DR estimate of arrival over the field with



nothing in sight, commenced a port orbit. He was unsuccessful in contacting the tower or approach control on UHF. He declared an emergency on guard channel and stated he was lost.

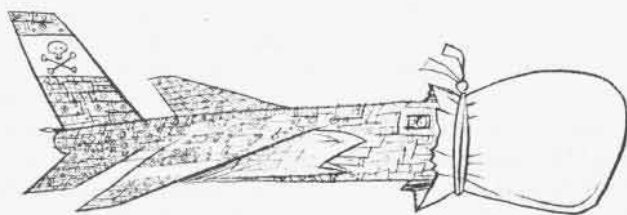
The *Vigilante* crew eventually received a DF indication of 300 degrees to the KA-3 orbiting the divert field. Later they were advised by an Air Force air evac flight that they were in the vicinity of the field. A strange radar site also came up on the radio and attempted to get radar contact. By this time the thirsty *Vig* had only 2,500 lbs. of fuel remaining. The RAN

rechecked their ADF bearing to the tanker on another frequency. It was still 300 degrees, so they decided to head NW and start a letdown. Several minutes later, lights were sighted through a hole in the overcast, and the descent was continued to arrive at 10,000 feet over the island.

The tanker had advised that he was orbiting the divert field but was nowhere to be seen. The airfield could not be sighted after a Cook's tour and, by this time, they were "low state." Unfortunately it was the wrong island.

Charlie Control, the radar station, advised that they were in radar contact and to steer 300 degrees. After turning in that direction and seeing nothing but black ocean, the lieutenant turned back toward land. He picked the largest town he could find, orbited it three times at 1,500 feet to attract attention and, with only 400 lbs. of fuel remaining, headed back to sea, climbing to 5,000 feet. As the engines flamed out, he advised the world they were ejecting, and out they went as the aircraft was in level flight at 220 knots.

The survival episode is a story in itself, but the crew was picked up, spent the night in a local hospital and returned to the carrier the next day.



6 million dollars!



Grampaw Pettibone says:

Great Balls of Fire! Chalk up another six million bucks down the drain. Regardless of how you cut it or who the fickle finger points at, *Command* must do something to stop this intolerable drain on our resources. The accident board said this one was caused by the failure of an inexperienced carrier pilot to follow established procedures and to utilize reasonable judgment. They knew he was inexperienced. Why wasn't he escorted all the way by the tanker? Why wasn't positive radar control exercised by the ship, under the circumstances? Although the RA-5 passed within 35 miles of its destination, it ended up over 120 miles NNE of the field. How do the cards stack up? (1) Loss of the aircraft radar, (2) unreliable aircraft IFF equipment, (3) weak UHF radio equipment, (4) malfunctioning heading indicator (compass), (5) undependable aircraft navigation equipment, including Tacan, and (6) unreliable and erroneous divert-field Tacan facility. The poor guys hardly had a chance. Course I'll admit, there is also a good possibility that there was a certain amount of fog in the cockpit of that *Vigilante* that night.

The Last to Know

The junior lieutenant and his bombardier/navigator (B/N) ate a hurried lunch in the wardroom of the CVA and joined the rest of the A-6 *Intruder* crews in the ready room for a thorough briefing of the forthcoming carrier buildup period. It was the carrier and air wing's shakedown cruise prior to deployment. The air plan called for three planes to make four arrested landings each, then hot refuel and "hot seat" with another crew.

Preflight of their aircraft showed a good plane and the Ltjg. B/N verified the 37,000 lbs. gross weight inscribed on the side of the aircraft for catapult setting. After the engines were started, he reconfirmed the fuel load at 9,000 lbs. and gave a "thumbs up" signal to the catapult weight checker on the port side.

As the *Intruder* was tensioned on #4 catapult, another A-6 was taxied toward the port bow cat and directed to spread its wings. No one noticed that one overlapped the flight path of the plane on #4 cat. As the catapult officer gave the fire signal, he suddenly became aware of the fouled launch path and immediately suspended. It

was too late. The unlucky plane was launched, striking the wing of the other craft.

The pilot encountered no control difficulties, and an inflight check revealed no visible damage. The *Intruder* landed back aboard shortly and an inspection of the wing showed only surface scratches.

They were held on deck and not advised of what was planned. The lieutenant was having some communications problems and was unable to transmit on UHF. His B/N could, however, so they continued to stand by. When the flight deck fueling crew began signaling to them, they finally understood that they should activate the refueling switch and assumed their plane was to be topped off to its previous 9,000-lb. load.

Some 15 minutes later, after completing refueling, they were unexpectedly unhooked and taxied toward the bow catapults. As it became apparent that they were about to be launched, the takeoff checklist was begun. Upon inquiry from primary fly as to gross weight, the B/N advised 37,000 lbs. and also Rogered the same to the catapult weight checker. The checklist was quickly completed, the pilot hurriedly checking the fuel gauges and confirming the B/N's evaluation of a 9,000-lb. fuel load.

Tensioning on the cat and the launch proceeded normally until the *Intruder* reached the bow where it be-

gan to settle rapidly. Twenty-five feet above the water, both crew members ejected while the aircraft climbed slightly, then dove into the sea. The plane guard helicopter rescued the men who had only minor injuries.



Grampaw Pettibone says:

Blub! Blub! Blub! (If ya wonder what that sound is, I'm cryin' in m' beer 'n who likes diluted draught.) What in thunderation is going on here. No wonder the bird wouldn't fly. They loaded that plane with 20,000 lbs. of JP-5 - not 9,000 lbs. Looks like too many people, includin' the crew, not talkin' to each other.

To start with, the pilot shuda' downed the plane for not having adequate radio gear. Kinda' looks like he put too much blind faith in his B/N and the people runnin' the show on that consarned ship. Sure and it's the pilot's fault, but blamin' him don't prevent accidents. That darn carrier set him up fer it like the beer bottle on the fence post. There's just no excuse in the world for that nugget lieutenant not being advised of his changed mission and changed fuel load.

I've sed it before, and I'll say it again. Fer nearly every pilot-factor accident there's at least one supervisory senior who erred more than the pilot. Seniors must continually consider their weakest link in the chain and plan for human error, misjudgment, immaturity, lack of training, et al, in every-thing they do.

'The primary cause of this accident is Administrative. I should have never been graduated from flight school.'

