



# GRAMPAW PETTIBONE

## All Star Cast?

A commander with a large amount of experience in the A-3 *Skywarrior* was assigned a routine carrier tanker mission. Two NFO's were his crew, a lieutenant commander and a lieutenant; both with substantial experience in A-3's. As time to man the aircraft approached, the SDO suggested that they man their EKA-3B — even though maintenance was finishing up a previous discrepancy on the auxiliary tank dump mast. The commander concurred. A normal preflight was conducted except for the empennage which was situated over the water and couldn't be checked. Starting engines was normal and the aircraft taxied onto the starboard bow catapult. Since the crew did not have an opportunity to preflight the dash pot pressure, the plane captain visually sighted the gauge while the aircraft was taxiing up to the catapult and found it to be in the normal range. The aircraft was launched and proceeded overhead the carrier for tanker package checkout and fuel consolidation with the off-going EKA-3B tanker.

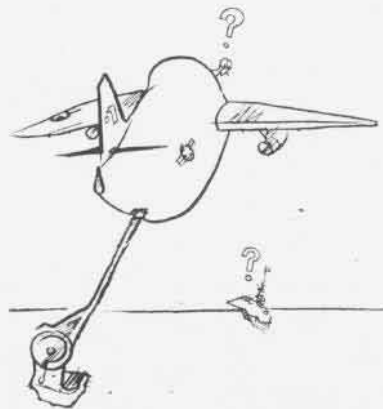
Checkout of the aircraft tanker package failed to produce fuel transfer, so the pilot retracted the fueling hose and selected wing and auxiliary tank dump, momentarily, in an attempt to reset any microswitches that might be causing a holding relay. Both functioned properly and, upon deselection, the dumping ceased. A second attempt was made to check out the tanker package but the system was still unable to transfer fuel to a receiver. After he informed tanker control of a "sour package," the pilot was instructed to climb to 20,000 feet. Reaching altitude, the commander conducted air target radar exercises for the remainder of the flight.

As the time for the next EKA-3B launch neared, the pilot terminated the exercises, switched to departure control and rendezvoused with the oncoming tanker to check out its package, which was also inoperative. Departure control was notified imme-



diately and our aircraft was shifted to approach control. The oncoming tanker climbed to a higher altitude. Once on approach control frequency, our A-3 was given a revised ETA of 2151 and requested to manage its fuel so as to arrive at the ramp with maximum trap weight. Fuel was computed by the crewmen and they determined that 2,000 pounds of the remaining fuel would have to be dumped in order to arrive at the ramp with required fuel and maximum trap weight.

The approach from overhead the carrier commenced on time. Dumping from the auxiliary tank followed shortly. The NFO dumped the re-



quired fuel and then secured the dump switch. However, the fuel quantity gauge revealed that the auxiliary tank dump hadn't secured. Several attempts were made, by cycling the dump switch, to halt the dumping, but the effort proved futile. Approach control was advised and a fuel state of 5,200 pounds was reported at 13 nm inbound.

The pilot was switched to the final controller and an approach was flown to mirror acquisition at  $\frac{3}{4}$  nm. At ball call, 4,800 pounds of fuel were reported. Shortly thereafter, a waveoff for a fouled deck was given by the LSO because a cross deck pendant was not fully retracted.

After initiating the waveoff, the pilot advised CCA of his fuel state, 4,200 pounds, and requested that he be turned downwind for his next pass. However, the CATTC officer, after consulting with the squadron's representatives, decided that the best course of action was to bingo the aircraft as there was no fuel available for tanking in the event the A-3 could not get aboard. The bingo, along with the bearing and distance to the nearest divert field, was transmitted. The pilot repudiated the bingo and asked for confirmation of his bingo fuel which was confirmed as 4,600 pounds. The pilot recommended that he be brought aboard since his fuel state was below the published bingo. Again the signal to bingo was passed but was later rescinded by the CATTC officer.

The aircraft was then vectored around for another approach but that one resulted in a hook skip bolter. Thereafter, the pilot elected a VFR pattern as fuel was becoming critical. The aircraft bolted on the following five passes and the decision was made to rig the barricade before the aircraft ran out of fuel and the crew had to bail out.

As the barricade was being rigged, the pilot retracted his gear to conserve fuel. Approximately six miles downwind with a fuel state of 2,100 pounds, the pilot turned in for the final approach. At six miles, on final, he reported he was holding his gear

and would put the wheels down at five miles. This was the first indication that either of the other two crew members had that the wheels had been retracted. The right seat NFO had completed the landing checklist after the last bolter; however, when the pilot told him the wheels were up, he made a mental note to recheck the gear down, later in the approach. (This was the last time any crew member thought about the gear position.)

As the aircraft reached five and one-half miles, the pilot concentrated on the approach. At five miles, the crew was informed that the barricade was ready, and they began final preparations for landing. At one-half mile, the LSO took over for the final phase of the landing, and the A-3 completed a wheels-up barricade arrestment. The craft suffered substantial damage; the crew was uninjured.



**Grampaw Pettibone says:**

Dad blasted! This is unbelievable! After this fellow dug himself a hole, the only assistance he received was other people digging the hole deeper. Amongst other things, no one, particularly the LSO, suspected a "hook problem." Appears to me that when a fellow makes a number of O.K. passes with continuous hook skips that it's time to become a "suspicious cuss"! And no one bothered to inform the CATTC officer that an additional tanker was ready to launch. Would you believe that there were seven other people on the LSO platform during that approach—and none noticed the lack of approach lights. This does not include the three people in the cockpit of the aircraft! With the number of people involved, there is not one solitary excuse that can be offered for this fiasco. If I were the coach of this team I would have a lot of substitutes in the next game. Yes, sir, looks like "while puttin' out the fire in the barn, the house burnt down." Nuff said.

#### **Meanwhile, Back in the Passenger Compartment**

After a three and one-half hour flight from another inland airfield, a C-118B *Liftmaster* made an uneventful night landing at NAS Midwest. The pilot in command had considerable experience, with over 2,000 hours in type. During landing rollout, a stack fire developed in number 4 engine and, as the aircraft cleared the

duty, the rpm decayed and number 4 quit. The pilot brought the transport to a stop while the flight mechanic cranked number 4 in an attempt to blow out the fire. Meanwhile, the passengers became somewhat alarmed by the flaming engine. The flight attendant, an airman with limited experience, for lack of other instruction, tried to prepare the cabin for emergency ground evacuation. He attempted to rig the escape chute but encountered difficulty opening the cabin door against the propeller blast from engines 1 and 2. A Marine sergeant passenger attempted to help him open the door.

The pilot, at the same time, secured engines 1 and 2, and the prop blast force on the cabin door stopped. The attendant lost his balance and fell out of the aircraft, head first. The sergeant fell out of the aircraft, too; however, he put his arms around the escape chute and slid down, burning his hands and arms. The young flight attendant was not so fortunate. He sustained major injuries to his right arm and both wrists as he attempted to break his fall with outstretched hands.

With all engines secured and the fire out, the passengers and crew exited the aircraft by the boarding

ladder. Investigation revealed no damage to the aircraft and the probable cause of the stack fire as poor pilot technique in transitioning from forward to reverse thrust during reversing procedures. Additionally, the aircraft public address system was inoperative and the emergency escape chute was not pre-rigged as specified in NATOPS.



**Grampaw Pettibone says:**

Great balls of fire! That young fella was extremely lucky that he didn't sustain major or even fatal head injuries. I can't blame this lad for attempting to do something in view of the circumstances and the lack of direction from the "drivers." Appears like we have a little "supervision problem" here—why wasn't the escape chute rigged to the deck as prescribed in NATOPS? Seems to me, once the aircraft was stopped, that the aircraft commander could've sent the flight mechanic or the copilot aft to assist this young fella. The maintenance people were no help on the public address system either, and additionally, the flight attendant interphone circuit was inoperative. All in all, this was an extremely poor example of crew control—namely, the complete lack of communication from the cockpit to the passenger compartment.

