



# grampaw pettibone

## One Dark Night — One Bright Light

A flight of two CH-53s was scheduled for night confined-area landing practice. The landings would be made both individually and as a section.

The wingman launched first, proceeded to the practice site, and landed. A crew member placed two portable landing zone lights in position to mark the northern boundary of the landing zone. The flight leader arrived, landed and had the remaining two portable landing lights emplaced to mark the southern landing zone boundary.

The flight then joined up and the lead aircraft copilot led the first three section landings. The wingman then assumed the lead position and executed four additional section approaches resulting in two wave-offs and two successful landings.

The flight then divided up as briefed and commenced individual landing pattern work. Following two successive landings by the lead aircraft copilot, the lead aircraft pilot took his turn at the controls. The



lead aircraft pilot's next three approaches were waved off due to overshooting the land zone. The fourth approach resulted in a successful landing. Hardly satisfied with his performance, the lead aircraft pilot elected to perform an additional land-

ing. The final approach was flown to a long, high straightaway. All flight instruments were functioning normally. A 10-15-degree nose-up attitude with an indicated airspeed of approximately 20 knots was noted as the aircraft passed 100 feet on the radar altimeter. The pilot used the forward right landing zone light as a line-up reference and tended to fixate on that light as the aircraft neared the zone.

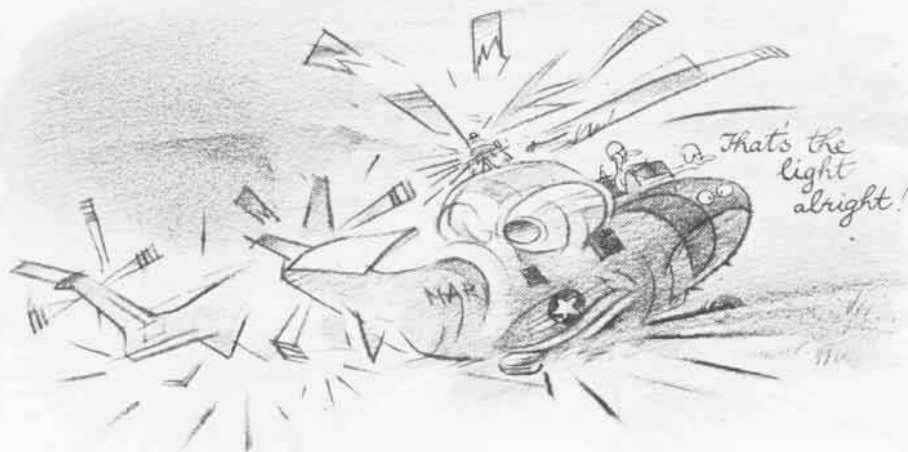
During the "final" portion of the approach, the pilot's scan deteriorated. Before either pilot realized the implications of the situation, the aircraft tail struck the ground. Both pilot's later expressed surprise because they felt they were still at least 100 feet in the air. The radar altimeter warning light (set at 25 feet) and the attitude warning horn functioned normally.

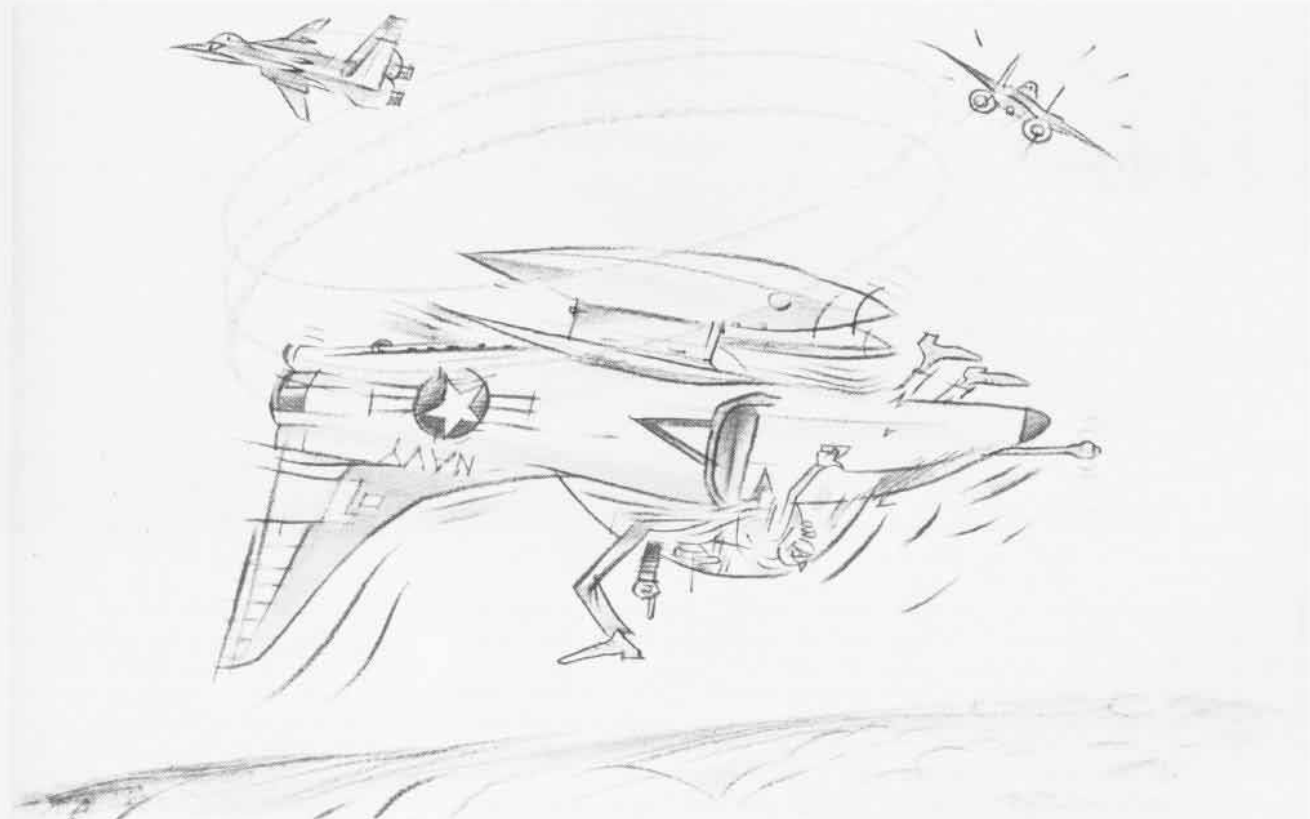
As the tail skid impacted and collapsed, the tail rotor blades struck the ground. The aircraft then began to roll left and yaw right with the main rotor blades striking the ground and disintegrating. The crew egressed uninjured and the aircraft was eventually consumed by fire.



Grampaw Pettibone says:

Great jumpin' Jehoshaphat! These guys are lucky to still be breathing. Why wasn't the copilot backin' this guy up on the flight instruments? Single-point light source fixation is a well documented problem. Perseverance certainly is a desired trait in a Naval Aviator, but only when it's tempered with caution, good judgement and common sense. Anytime you're flyin' an aeroplane in IFR conditions (and pitch black is IFR) while employing a VFR scan, the IFR then connotes, "I'm flying recklessly." Pride notwithstanding, and as any professional knows, you, and only you, know your limitations on a given flight. A little bit embarrassed is acceptable, but there's no such thing as a little bit dead!





## Hey! Who's in Charge Here?

After a thorough brief for an advanced tactics support mission involving two F-14s and one TA-4, the crews manned up for takeoff. The *Skyhawk* departed NAS Home Plate followed by the *Tomcats* and proceeded to the ACM area. Two normal intercepts and ACM engagements ensued. The third intercept was terminated prior to the ACM engagement when an errant F-4, piloted by a heads-down Ace Laroo, passed through the tactics area.

At the start of the fourth intercept, the TA-4 was vectored to the F-14s to start the final engagement. The *Skyhawk* passed close aboard one of the F-14s commencing the engagement and started a level starboard turn at approximately 375 knots and 22,000 feet.

After about 180 degrees of turn, the TA-4 pilot visually acquired the second F-14 at his 4-5 o'clock position. The TA-4 pilot continued the starboard turn into the second F-14 and increased the aircraft G loading

to 3-4 Gs. The *Skyhawk's* airspeed dropped off to 325 knots. It was at 21,000 feet in a 90-degree angle of bank, nose slightly low.

The TA-4 almost immediately departed controlled flight with a violent right roll and negative G loading. The aircraft then experienced a high yaw rate with continued negative G loading. The pilot was forced up and forward against the glare shield while the rear seat copilot was forced up into the canopy.

Because of extreme buffeting, neither the pilot nor copilot could read the instruments. Perceiving that the aircraft was in an inverted spin, the pilot initiated anti-spin controls for an inverted starboard spin at approximately 17,000 feet, with no apparent effect. Passing through 12,000, the copilot initiated command ejection from the rear seat. The ejection sequence was normal and both TA-4 crewmen were rescued.



Grampaw Pettibone says:

Oh, my achin' corpuses!

Investigation revealed that the copilot ended up with command ejection capability due to a failure to preflight the front cockpit ejection selector. During the preflight briefing the pilot in command stated he would maintain the command eject function in the front seat. Missed preflight items can ruin your whole day. Ten thousand feet is squadron SOP for emergency ejection. The pilot had initiated anti-spin controls and was trying to work the problem out. Because of a premature ejection, we will never know for sure whether the plane would have recovered. It would have been some help if the rear-seater had offered some information, such as type and direction of spin, altitude, etc.

At least the copilot could'a inquired about the pilot's desire to leave the aircraft. Granted, it's awful hard to reach the intercom switch when you're pressed against the top of the canopy but, sufferin' catfish, what about hot mike? When you're in a dynamic operating environment, it behooves you to use the old noggin and have instant communication with other crewmen. A decibel of noise can save your poise! No one is immune to preflight or crew coordination complacency. Young tigers take heed!