Grampaw Pettibone

T-for-2 Taxi

A T-2C *Buckeye* piloted by a student Naval Aviator (SNA) and instructor pilot (IP) was scheduled for a FAM safe-for-solo check. The brief was completed as scheduled but takeoff was delayed due to late aircraft assignment. Starting was routine, the aircraft was cleared by the final checker, and the IP took control, telling the SNA to complete the takeoff checklist. The student complied, then assumed control of the aircraft and continued taxiing, choosing to remain on the left side of the taxiway.

The IP then directed him to call for takeoff clearance. The student switched to tower frequency, made his request and was instructed to hold short. The student acknowledged.

The instructor encouraged him to add some power to maintain speed while taxiing up the incline to the hold-short line. The IP then became aware that the aircraft was too close to the left side of the taxiway and told the SNA to come right. The student, who had directed his attention back into the cockpit, looked up and tapped the right brake. Unfortunately, the left wheel was already off the taxiway at a point where the shoulder was badly eroded, creating a 14-inch drop-off.

The aircraft came to a stop after the left wing-tip impacted the edge of an adjacent asphalt mat area. The instructor saw fuel leaking from the left wing fuel tank, reported the situation to the tower, and shut the aircraft down.

Grampaw Pettibone says:

Dang it all, this is just plain old dopin' off! The simple truth in this

case is that the IP overloaded an inexperienced SNA, in an attempt to make up a few minutes of ground operation time. The student's attention was diverted from controlling the aircraft. Both flyers failed to properly monitor the aircraft's position on the taxiway until a mishap was unavoidable. Had the IP been more attentive, and applied the right brake himself instead of directing the student to do so, he could have stayed on the taxiway. This violates a Gramps' rule for instructors during taxi: "Don't divert the duty driver with distracting directions and doze while he drifts disastrously into the ditch."

Misaligned Maintenance Misfortune

The mission, although unknown to this crew, was to be an unscheduled A-6E catapult ejection exercise following a 1330 launch. The aircraft, number 505, taxied into position on the number one catapult and was readied for launch. As the catapult fired, the B/N, in his normal procedure, turned his head to observe the left side of the cockpit. He saw the pilot's VDI control box come out of its mount and jam between the stick and the forward instrument panel, forcing the stick full aft. The B/N informed the pilot of the problem. Leaving the catapult, the aircraft immediately pitched 70 degrees nose-up. The pilot was unable to move the stick forward. Realizing the situation, the B/N attempted to initiate ejection with the lower ejection handle, while pointing to the control box with his left hand and transmitting "eject" over the ICS. The aircraft climbed to 140 feet and began a slow right roll. The B/N exited shortly after the nose yawed to the right, at 60 degrees nose-up and 80 kias. The pilot ejected after his third attempt to grab the lower handle. The aircraft continued to roll off to the right, pitched nose down and impacted the water 12 seconds after launch.

Grampaw Pettibone says:

Great sufferin' supervision! Accidents like this make your hair stand on end. One look at this maintenance program revealed more loose ends than a double tub of spaghetti.

On the evening before the accident, a fire control technician (AQ) was directed by his shop supervisor to troubleshoot four discrepancies on aircraft 505, located on the flight deck. The supervisor failed to notify maintenance control that the aircraft was going in or out of work at any time. The AQ corrected one discrepancy, troubleshot another and was working on a third (B/N's VTR control box) when another AQ offered to assist with the fourth discrepancy, a malfunctioning VDI pilot's control box (PCB). They decided to trouble-

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shoot the problem by swapping a good PCB from aircraft 504. The first AQ removed the good PCB from 504 and then went back to work on the B/N's VTR control panel. The second AQ connected the PCB cables and slid 504's box into place in 505 but did not secure any of its fasteners. When he discovered that the swap had not cured the discrepancy, he informed the first AQ but failed to tell him the box was not secured. He left the suspected bad PCB on the pilot's seat and began to assist with the work on the B/N VTR. When this repair proved unsuccessful also, the second AQ left to work on another aircraft. The first AQ now secured the B/N VTR, closed the aircraft canopy, and took 505's original PCB to 504 and installed it.

He informed his supervisor of this action but did not mention the second AQ. A maintenance action form was signed off for the first discrepancy and time was logged against the others.

The supervisor was the only night shift quality assurance collateral duty inspector (CDI). Trusting the work of the technician, he made only a casual inspection of 505's cockpit from the B/N boarding ladder by shining a flashlight through the canopy. Rain showers were falling on the flight deck and he did not want to open the canopy and get the parachute and cockpit devices wet. He knew of the cannibalization but failed to inform maintenance control.

The canopy was not opened again until about one and one-half hours before launch. A thorough cockpit check was never made.

You would think that one of four guys (tech, CDI, plane captain or pilot) would have discovered this loose PCB. Particularly, when this very piece of gear has cost us aircraft and lives before by coming loose on cat shots. It should be considered a safety-of-flight item for CDI and preflight inspections.

Dang it all, gents, this is another costly example of how a job that's only half done is worse than one that isn't done at all. Just how many birds do we dump in the drink before we get the big picture?