



GRAMPAW PETTIBONE

"Who's On First?"

During landing rollout on his sixth day of carrier-arrested landings, the A-7 Corsair pilot inadvertently retarded the throttle back past idle to the engine cut-off position. Hearing the engine unwind, he realized his mistake and immediately returned the throttle to the idle position. He quickly attempted to transmit to the tower that he had shut the engine down but the generator had dropped off the line, so his transmission was not heard. Another aircraft was turning at full power on the catapult, so he did not realize that his engine had not stopped but, in fact, had returned to idle RPM. (He failed to note the RPM gauge which is the only engine instrument that operates without generator power.) Thinking the engine had quit, the pilot now believed that with the throttle at idle position he was dumping raw fuel into the windmilling engine; so he again pulled the throttle to engine cutoff position. Again he detected the engine unwind, but this time a check of the RPM gauge confirmed that the engine was, in fact, running at idle, so he quickly returned the throttle to idle position. He then reset the generator, restored electrical power and notified the tower of his status. He was finally taxied from the landing area and parked abeam the island structure to realign the IMS prior to launching to the beach.

After a coarse IMS alignment, the pilot determined his aircraft's approximate magnetic heading by adding his aircraft's relative heading on deck to that of the ship's heading which he remembered during landing. He dialed 240 degrees into the HSI course window and slowed the IMS to that heading. He was unaware that the ship had altered its basic recovery course by 45



degrees to port since he had landed.

The pilot then informed the tower that he was ready for launch but did not report his fuel state (1,900 pounds). The A-7 bingo fuel requirement reported by the tower was 1,600 pounds. He did not request, nor was he given, the ship's new heading (190 degrees). He taxied to the catapult, checked 240-degree heading on his HSI, and was given a steer of 015 degrees, 75 nm to home plate.

After launch, he executed a normal Case 1 departure and reported level at 7,500 feet. He acquired a tacan lock-on to home-plate bearing

015 degrees and executed a right turn to proceed directly to the station. His tacan distance-measuring equipment was inoperative. He attempted contact with GCI control for inbound flight following but, after his third try, was told by another pilot to stand by as GCI was busy.³ Proceeding on, with five minutes into the flight, the pilot was startled to see the "low fuel" and "master caution" lights illuminate. The main fuel needle indicated 1,700 pounds with 1,400 pounds showing on the digital totalizer. The pilot reduced throttle to establish maximum range profile. Up to this point, he had been proceeding 015 degrees on his HSI, at 7,500 feet and 330 KIAS. He declared emergency fuel state but still had no direct contact with GCI. Throughout the remainder of the flight, all communications between the A-7 and GCI were relayed by other aircraft.

GCI interrogated his mode III IFF squawk, and informed the low-fuel A-7 pilot that he was "radar contact." This was in error, however, as the radar contact was a second A-7 (#2) who had launched 10 minutes later and was proceeding inbound on the 195 radial. Both aircraft had been assigned the same mode III squawk, as they had been in the same flight to the ship. A third A-7 (#3) had also been launched and was tracking inbound, approximately 15 miles behind #2. GCI vectored aircraft #3 toward #2, thinking that #2 was the low fuel aircraft — not knowing that A-7 #1 was proceeding northwest on a course of 330 degrees, some 40 miles west of #2 and #3.

The pilot of aircraft #1, hearing all the airborne transmissions, assumed that he was in radar contact, and that aircraft #2 was proceeding to join on him from behind. At this point, the

pilot noticed that he was steering 015 degrees magnetic on his HSI but heading 330 degrees on his standby compass, and transmitted that his gyro had failed. He was advised by another aircraft to disregard his gyro and steer 015 on the standby compass. He immediately executed a 50-degree turn to starboard.

For the next five minutes, GCI continued to vector #3 to join on #2. After join-up, the pilots of #2 and #3 realized the mistake and reported their position as 195 degrees/25 nm NPA. The GCI controller correlated this position with the aircraft they had thought to be #1.

Overhearing these transmissions, the #1 A-7 pilot checked his divert chart, and reported that he was now in sight of some islands southwest of Mobile Bay (some 60 miles west of Pensacola). He realized that he did not have sufficient fuel (900 pounds) to reach Pensacola. Twenty minutes had now elapsed since his low fuel light illuminated. He switched to "emergency" IFF and climbed to 19,000 feet to seek a suitable landing field.

The GCI controller expanded his radar range scale and located the aircraft via his emergency IFF squawk at 260 degrees, 50 nm from Pensacola. With the assistance of an alert Pensacola approach controller and the pilot of A-7 #3, the low-fuel Corsair was directed to Brookley Field in the northwest corner of Mobile Bay where he performed an idle, maximum-rate descent from 19,000 feet at 15 nm southeast of the field. Transition to landing configuration was accomplished at 1.5 short of touchdown, crossing the runway threshold at 160-170 KIAS. The pilot felt he would not be able to stop the aircraft safely with that speed and executed a go-around, effecting a very tight pattern to a safe landing.

The engine was secured with 300 pounds of fuel indicated on the main needle and zero on the digital totalizer.



Grampaw Pettibone says:

Holy bungled birdfarm bingo! This is just too close for comfort. And the fact that there have been two similar A-7 bingo incidents within two months is just *too* much! The first incident resulted in the loss of an A-7E when the engine flamed out .9 nm short of the runway. It is sad to see that the important lessons which should have been learned in the first mishap were not.

Specifically, the inexperienced pilot failed miserably in making proper use of available aircraft equipment and facilities and procedures. Additionally, carqual supervisory personnel failed to adequately monitor the CQ evaluation, particularly after viewing this young lad's idle-wild demonstration in the arresting gear.

The mishap board was directed to investigate this near-mishap just as though a class "A" mishap had occurred — as it dang near did. The dif-

ference in this case is that all pertinent materials (aircraft, pilot, supervisors, statements, etc.) were available to analyze lessons learned (of which there was a bunch). Now, let's make some use of them.

Gents, each year we see three to four CQ bingo calamities make headlines and most of them are copies of each other. You can rest assured that there are many other close calls that didn't make the press and are passed off with an "all's well that ends well."

In view of the frequency of these CQ fiascos, Old Gramps thinks it's time we fall back a step or two and take stock of our procedures, and treat bingos like the bonafide, unplanned, unprogrammed emergencies that most of them turn out to be.

How sad it would have been had this lad flamed out on the go-around after finally finding a field. He landed with tanks so dry that the first 50 gallons soaked into pores of the tanks when refueled.

