

GRAMPAW PETTIBONE

No Room to Assume

"In the groove, do you have a ball?"

"Cobra 112, *Phantom* ball, state 4.3"

"Roger ball."

The carquel evolution continued. Then over the flight deck SRC-22VFH hand-phone circuit came a call of "Foul deck! Foul deck!" from the arresting gear officer (AGO). He had observed a cable support malfunction during arresting cable retract. The air boss, hearing the foul deck call, turned to switch the aft rotating beacon from green to red – to "close" the deck. Two flight deck crewmen ran into the landing area to inspect the arresting cable and repair the malfunctioning cable support bracket as an F-4, which had just landed, taxied clear of the landing area. The arresting gear maintenance officer, running aft to supervise the wire support repair, observed the AGO in the landing area with his outstretched arms crossed overhead – indicating a foul deck.

"Roger ball," acknowledged the controlling LSO. Cobra 112 appeared on the center line, wings level, with two men visible in the landing area.

"That's good. . .now hold it up there . . . a little more power."

"Right for lineup," called the backup LSO as the incoming F-4 neared the ramp.

"Bolter! Bolter! Bolter!" called the LSO as the *Phantom* landed. The arresting hook skipped the #3 wire but picked up #4. The *Phantom* slowed somewhat, then, with throttles at full power, became



airborne after the #4 arresting cable parted and whipped violently across the deck. Miraculously, no one was injured by the cable. The pilot assessed the situation and diverted his slightly damaged aircraft to a safe landing at a shore base.



Grampaw Pettibone says:

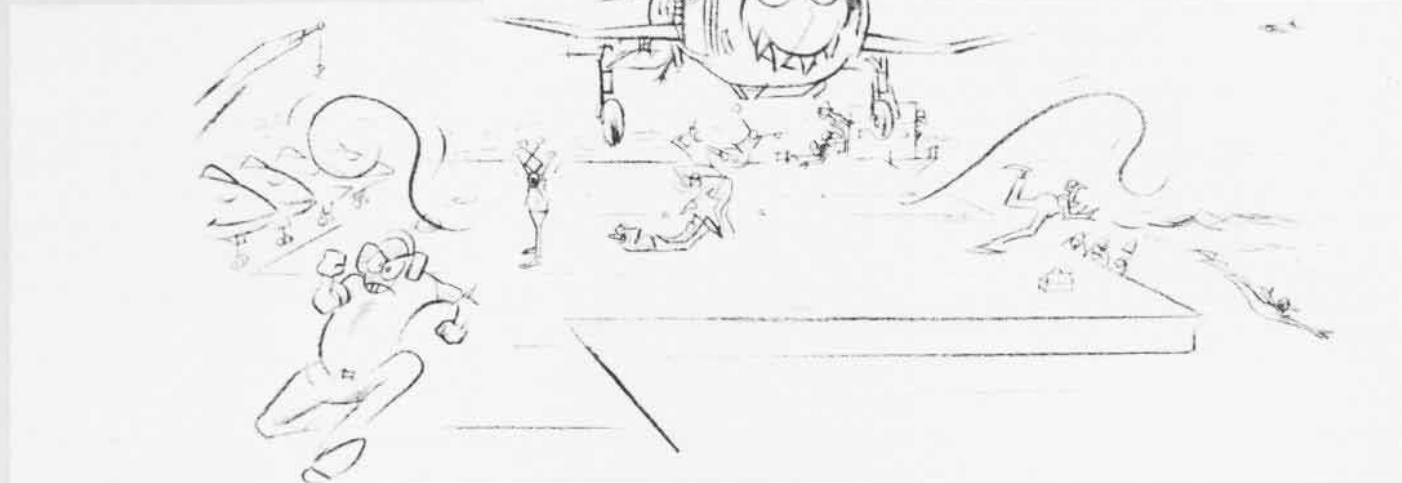
Holy assassinating assumptions! This is enough to make grown men cry, or even worse, die. It was more than miraculous

that no one was injured in this foul deck fiasco. The incident illustrates the potentially catastrophic results that can occur when well-trained and qualified members of the carrier aviation team "assume" things other than their own responsibilities.

The LSOs, directing their attention to the approaching aircraft, assumed the deck to be clear. They failed to observe the men in the landing area and assumed someone would tell them (the LSOs) if the deck were foul. The LSO phone-talker assumed the LSOs heard his repeated foul deck calls. The air boss assumed that the LSOs knew the deck was foul and assumed they would wave off the approaching F-4 since there was no chance for landing. He diverted his attention from watching the deck to getting more aircraft into the pattern, and failed to announce "foul deck" over the flight deck 5mc loudspeaker circuit.

The two wire-check crewmen directed all their attention to repairing the wire support, with no one "hawking" approaching aircraft. They assumed someone would warn them of impending danger. Fortunately, one of them spotted the landing F-4 in the nick of time and they fled the landing area as the aircraft passed over them.

Too many assumptions here! It seems to old Gramps that we go through some variation of this disaster almost annually. Fortunately, on this occasion, the grim reaper missed his mark. But you can be dang sure he'll return when we least assume that he will. (November 1979)



ILLUSTRATED BY *Osborn*

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, troubleshooted 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 troubleshoot 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 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?

(August 1980)

