

Illustrations by *Ted Wilbur*

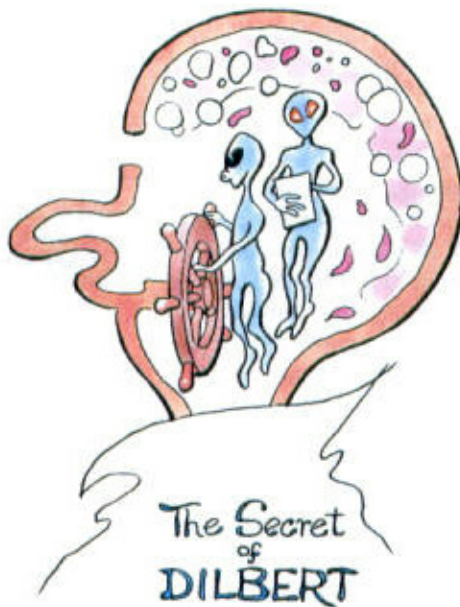
## Hornet Hit

A four-plane flight of F/A-18 *Hornets* was on a strike fighter advanced readiness phase (SFARP) training mission—a night, radar, “opposed” (by adversary aircraft) forward-looking infrared sensor strike mission—which is very demanding and requires a high level of aircrew proficiency. The mission commander was an A-6 *Intruder* transition pilot on his first *Hornet* tour. He had flown eight hours in the last 30 days, 1.3 hours of which were at night, and one hour in the last seven days. The squadron had been on a reduced turnaround cycle and had been unable to fully conduct the usual predeployment proficiency training.

The mission commander assigned another pilot, Dash 1, to brief and lead the flight. The mission commander flew as Dash 3 on the leader’s port wing. The flight proceeded to the working area and using a “fluid four” formation, established a 500-knot ingress airspeed toward the target.

Dash 3 began experiencing lateral position errors relative to Dash 1 and made numerous heading corrections to stay in position. This was probably due to the reduced lighting conditions and/or possible awareness of an oncoming bogey flight which was about 40 miles away.

At one point, according to others in the formation, it appeared that Dash 3 was trying to cross under Dash 1’s aircraft. In addition, Dash 1 inadvertently slowed to 460 knots. This,



combined with Dash 3’s 20-degree deviation from course, established a collision bearing that went unnoticed.

Dash 3 started to make a radio transmission, but it was interrupted as the two aircraft collided. Dash 1’s port wing impacted Dash 3’s cockpit/turtleback area. Dash 3’s aircraft broke into three parts and exploded. The pilot did not eject and was lost. Dash 1’s *Hornet* broke into two sections, but the pilot successfully ejected.



Grampaw Pettibone says:

**Go! dang it! You could almost see this one comin’ before the flight got off the ground. Dash 3 was put into a position that just might have been beyond the necessary experience level at this point in the syllabus. This SFARP mission is one of the toughest to execute, especially because it’s played out in the dark and at high speed.**

Naval Aviation owns the night, the saying goes, as epitomized by Operation Desert Fox. We **MUST** train for the night, but lost situational awareness rears its deadly head at will, particularly after sunset and before sunrise.

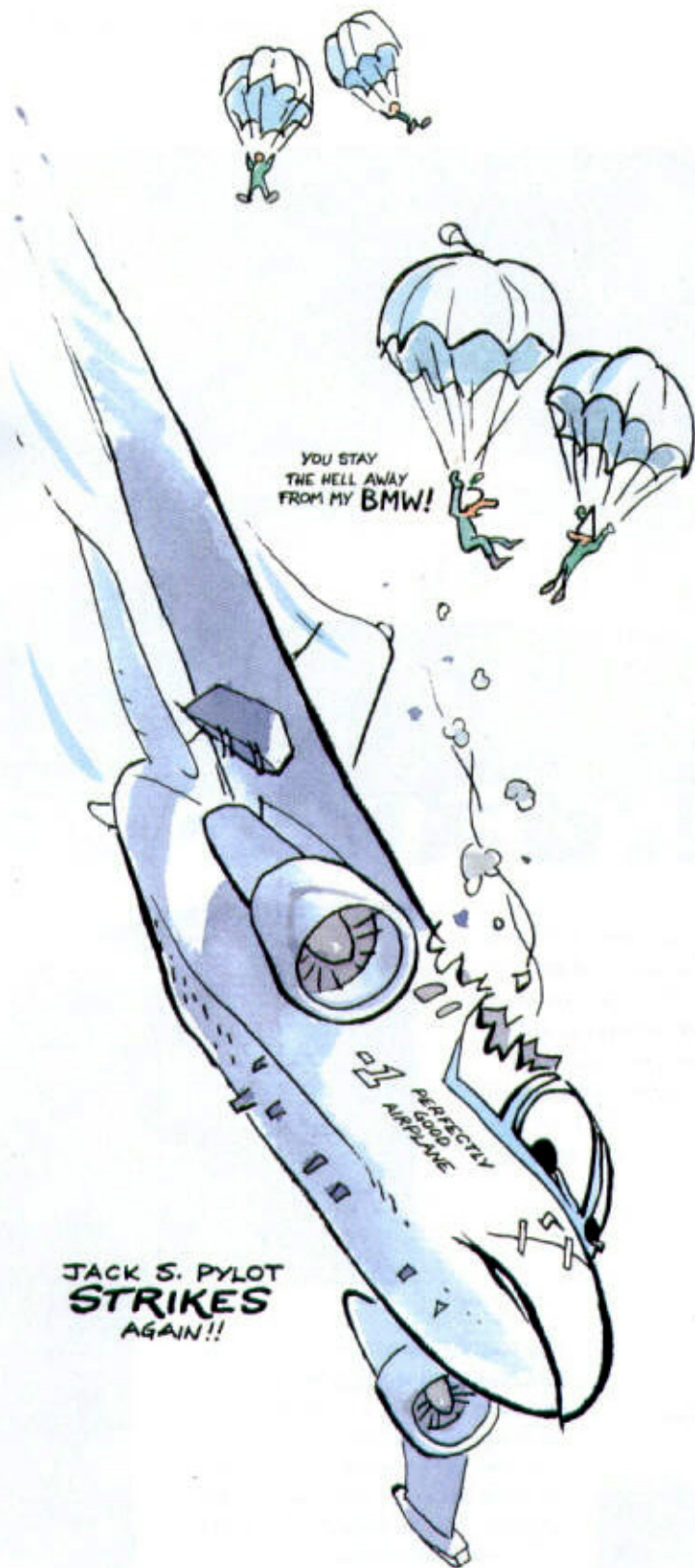
In this case, it would have been better, the investigators noted, “to limit the complexity of tactical planning, employment and execution to a level commensurate with aircrew proficiency.” That’s not easy to do, but we’ve got to do it. The compressed turnaround cycle was surely a factor in this tragedy.

## Vikings Away

An S-3 *Viking* with four in the crew was on a familiarization flight for a copilot/tactical coordinator (COTAC). Although the COTAC had more than 1,100 hours in model, this was his first flight after being out of the cockpit for over three years. During the preflight briefing, the pilot did not discuss specific aircraft coordination and communication requirements as was dictated by air wing standard operating procedures.

In the training area, the pilot initiated entry into a





cruise configuration full-stall demo at 13,000 feet. The *Viking* progressed normally into the stall with buffet and wing rollout occurring at the appropriate angle of attack (AOA). This rollout tendency is a

normal S-3 stall characteristic and is one of the several indicators used to determine that an aircraft has entered a fully stalled condition.

However, the pilot did not ensure that the AOA was adequately

reduced prior to power application. As a result AOA increased and a deeper stall occurred. The S-3 entered a post-stall gyration (PSG), completing nearly two gyrations before the pilot applied out-of-control flight recovery procedures due to the delayed recognition of the PSG.

At this time, the attention of the pilot and COTAC was focused on illuminated trim/speedbrake and master caution lights. Mistakenly believing that these cautions were associated with the departure, the pilot removed his hand from the stick to reconnect the trim/speedbrake channels on the flight control test panel. The aircraft was now 45 degrees nose low, 50 degrees left wing down, and passing 10,000 feet with increasing airspeed as the pilot placed his hand back on the stick.

As the pilot applied recovery control inputs, he noted 8,000 feet on the altimeter, considered ejecting but believed the aircraft was recoverable. He did not convey this to the crew nor did the crew recognize indications of recovery from out-of-control flight. An ejection call was made over the intercom and command ejection was initiated above 6,500 feet with 250 knots airspeed. All hands were rescued within 30 minutes with varying degrees of survivable injuries.



**Grampaw Pettibone says:**

**Sing my socks and pass the bicarb! What happened to professional briefings and knowing proper stall recovery procedures? This isn't the old days when biplane drivers plowed into weeping willows with some regularity, walked away from the crashes and later chuckled about their brush with the Grim Reaper. When there's more than one in the crew, coordination and communication have to be treated as absolute milestones in the briefing process. Knowledge of stall recovery procedures and out-of-control flight wouldn't hurt, either.**