GRAMPAW PETTIBONE

Organizational Errors

A recent crash at a primary training station brought to light several serious errors in operational organization and procedures:

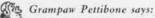
a. The pilot had been assigned to the flight list, although he had not officially been returned to flight duty, following a recent illness.

b. The pilot took up an unauthorized passenger.

c. Pilots were not required to sign Form N.Aer. 3119 (yellow sheet) upon completion of a flight.

d. Aircraft were not logged out or in by the tower watch. (Location of tower prevented this.)

e. Aircraft were not specifically assigned to plane captains, hence no check was made when planes returned to the line, nor at night, before secure.



The station concerned has taken action to correct this slipshod mess, but the information is passed along to warn other squadrons to make a careful check to insure that they do not have some of the same or other similar dangerous operational deficiencies.

Scavenging Trouble

A TBF was engaged in high altitude glide bombing. During the fourth dive with engine turning over at 1500 rpm's and with about 10-15" of manifold pressure, a large amount of oil was lost. Oil pressure dropped to 40 pounds and a partial engine failure occurred, necessitating a deferred forced landing during which the aircraft was severely damaged.

COMMENT—Nineteen hundred rpm's are recommended for glides and dives in the TBF and TBM. If a lower rpm is used for prolonged glides, the oil in the engine will load up in the nose section and be beaten into a foam which will then result in scavenging trouble and also loss of oil through the breather. Nineteen hundred rpm's are sufficient to prevent this trouble.





Winter Accidents

Winter flight operations are fraught with extra hazards. Ice, fog, snow, rain, sleet, frost and obstructed runways are some of nature's contributions to winter accidents. The following cases are typical accidents from last winter's record:

1. An SBD pilot on a cross-country flight elected to continue into a snow storm, and crashed. Evidence indicated that both carburetor and structural icing forced the pilot to attempt an immediate landing, during which he lost flying speed.

2. An N2S, although developing full power on take-off, was unable to gain sufficient air speed to clear obstructions at the end of the runway. Take-off had been attempted with a thin layer of frost on the upper wing. BuAer Manual warns pilots to inspect aircraft for icing or frost deposits on wings prior to take-off; it states, "A slight deposit that is barely visible may double the wing drag and greatly reduce available lift."

3. An SNJ came in for a night landing on the designated course and, after contacting the ground, struck a large pile of snow which had not been cleared from the edge of the runway. There were also several take-off crashes which occurred because runways were only partially cleared of snow.

 An SNJ-4 pilot failed to apply carburetor pre-heat in time to avoid carburetor icing. The engine lost power, necessitating a forced landing which proved fatal.

5. A flight of five F4F's took off for carrier qualification and about one minnte after leaving the field, flew head-on into a local snow squall which they could have easily avoided. One pilot became disoriented before breaking through the storm. He was seen to go into a steep, diving spiral and crash.

6. A PV-1 was landed with one wheel on a clear portion of runway and the other wheel on a strip of ice. When brakes were applied, they were ineffective on the wheel which was on the ice and a very serious groundloop resulted.

Grampan Pettibone says:

All of these accidents could have been avoided if proper consideration had been given to winter operating conditions.

This warning should have been issued sooner, but it is still not too late to close the stable door.

The same type accidents will happen again this winter if we don't watch out. Study the special winter hazards and know how to avoid or combat them. Learn about structural and carburetor icing. Stay out of storms if you can, but if you get caught short, go on instruments in time. Be sure your wings are clear of snow or frost before take-off. Be leary of your brakes on icy runways.

Flight control groups bear added responsibility at this time. It is mandatory that pilots be furnished accurate weather data for all flights. Also, field management must insure the largest possible area of cleared runways.

Attention Patrol Plane Pilots

There is considerably more to being a good patrol plane pilot than being able to fly, as shown by this accident.



A patrol plane commander, 625 hours, landed a PBY-5A in semi-sheltered waters during a period of reduced visibility. He was heavily loaded and experienced considerable difficulty in his take-off when the weather cleared. The pilot apparently considered he handled the ensuing emergency satis-

factorily, but the Trouble Board was not convinced. They reported:

"At about 60 knots he bounced badly and opened up the bottom, so he cut the throttles. Leaking badly, he headed for shore with full power, overheating the engines (300° cyl. head temp. for 10 minutes). He attempted to lower the landing gear while moving at excessive speed, ripping off the nose wheel doors and making the gear inoperative. He finally beached the plane among rocks, staving in the bottom.

"After removing only the bombsight and confidential publications, a guard was posted, and the remainder of the crew departed. All watertight doors were left open and no effort was made to keep the water out of the plane. It consequently filled with the incoming tide, submerging much of the equipment before a salvage party arrived."

Fire Hazard in Patrol Planes

A PBY-5 airplane was recently lost in the Pacific area due to a gas fire in the mechanic's and navigator's compartment. Upon being notified of a fuel leak in the cabane section, which was flooding



the navigation compartment with gas, the pilot ordered the floats lowered in order to make an emergency landing. When the switch was thrown to lower the floats, the float motor sparked, igniting the gas, and resulting in loss of the aircraft and fatal injuries to two crew members.

COMMENT—Crews should be indoctrinated to report immediately to the pilot the detection of gas fumes or leaking gasoline in the fuselage. Upon receipt of such report, the pilot should immediately direct the radioman to cut off all electrical power. Power should be left off until it has been determined that there is no longer any danger of fire.

In the event that an emergency landing is necessary, any equipment required for landing which is normally operated electrically should be operated by hand, utilizing the emergency provisions provided.

Poor Field Control

An SNJ had received take-off clearance from the tower and had started its take-off. At the same time, three SBD's which had been practicing field carrier landings were taxiing across the upwind end of the runway in use. The SNJ was making an instrument type take-off with the rear seat pilot at the controls. The safety pilot (instructor) was unable to see straight ahead owing

to the three-point attitude of his airplane, and relied entirely on tower clearance. He did not see the SBD's and just as his plane was airborne, it struck the wing tip of the second SBD and fell back on the runway. Luckily no one was seriously injured.

It was the opinion of the Trouble Board that this accident was entirely avoidable and occurred as the result of poor field control.

Sauce for the Gander

Pensacola claims this one:

During a final check in the Intermediate Instructors' School, the instructor ordered the ensign student to raise the flaps after take-off. The student asked the instructor to take over while he carried out the order.

"No, you do it; this is your check,' the instructor replied.

"But I can't get the flaps up with one band," countered the ensign impatiently.

"Well, you'll have to manage somehow. I'm just the passenger and don't know a thing about a plane," the instructor purred.

The ensign, with no choice, managed to carry out the order.

"Now, how do you know they're up?"
the instructor asked.

"What the hell do you care!" the ensign snapped. "You're just the passenger!"

Importance of Prescribed Altitude

Upon returning to base field, a student pilot joined the traffic circle at 400 feet instead of the prescribed 500 feet. Another student was climbing after take-off and instead of leveling off at 300 feet in compliance with course rules, climbed to 400 feet. The two planes collided and fell out of control; neither pilot managed to bail out.

Grampaw Pettibone says:

Now, do you see why it's so important to fly at the exact altitude prescribed in course rules?

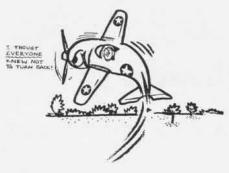


Don't Turn Back

The engine of an FM-1 failed at about 150 feet on take-off. The pilot tried to turn 90° to get into a clear pasture but stalled and spun in.

Grampaw Pettibone says:

Here is another pilot who was killed because he forgot the emergency procedure taught him in primary training. He knew that if his engine cut out on take-off he should first shove his nose over to keep flying speed and then consider the wind and terrain. But in the excitement of experiencing the real thing, he forgot the first and most important part of the emergency procedure. He lost flying speed!



The record shows that a spin is the most dangerous type of accident. If you can get your wheels on the ground with the airplane still under control, your chances of "walking away from it" are infinitely better than if you lose control and spin in.

Better check yourself mentally on this take-off emergency procedure and make sure that you will react in the right way. Remember, the first thing to do is get that nose down and don't start a turn until you have plenty of flying speed.

Why Doesn't Somebody Tell Me These Things?

An SNB-1 ferry flight was routed north through Richmond. Upon reaching the vicinity of Richmond, clearance to the north was refused due to "instrument" weather. The pilot was unable to orient himself in this area. Owing to approaching darkness and low fuel supply, he elected to land in the first available field. The emergency landing was a failure. The pilot and passengers received serious injuries and the plane was badly damaged.

Neither the pilot nor co-pilot was aware that the Richmond radio range had been changed. The courses had been realigned and the "A" and "N" quadrants had been reversed. The change had received full publicity, but the pilot had relied upon an old chart.

Grampaw Pettibone says:

Quite possibly this pilot might have been able to orient himself around Richmond had radio ranges been correct.