



grampaw pettibone

Maintenance Error

Two student pilots and their instructor pilot launched in a TS-2A for a night-safe-for-solo check flight. The flight was routine until the landing gear was raised after a touch and go. The wheel position indicator showed the starboard main mount unsafe with the gear handle light on. The handle was recycled normally with no change. Determining that the starboard main landing gear would not extend by using the normal hydraulic system, the instructor attempted to pump the gear down with the emergency hydraulic system. When this failed, he executed high-G maneuvers in order to try to get the gear to extend.

After repeated unsuccessful attempts to lower the stubborn main mount, he decided to execute an intentional gear-up landing, making an arrestment under the control of an LSO. Problems hampering the situation were reduced weather visibility and the pilot's inexperience at operating under the control of an LSO.

It was decided that the approach would be executed with the taxi light off so as not to hinder the LSO's capability in accurately determining aircraft sink rate. Since the taxi light was not used, the instructor experienced difficulty in determining his altitude during the last 50 feet of descent. The radar altimeter was unreliable and the barometric altimeter was inaccurate at that low an altitude.

The pilot relied solely on the LSO's commands. He briefed all crew members on their respective duties during and after the landing. After practicing several LSO-controlled approaches, the final one was executed. The LSO commanded the cut. The engagement with the arresting gear resulted in an unintentional inflight arrestment. The majority of the damage was sustained as the aircraft impacted the runway



after the inflight arrestment. The crew safely exited by jettisoning the main hatch. There was no post-crash fire.

Post-accident inspection of the air-

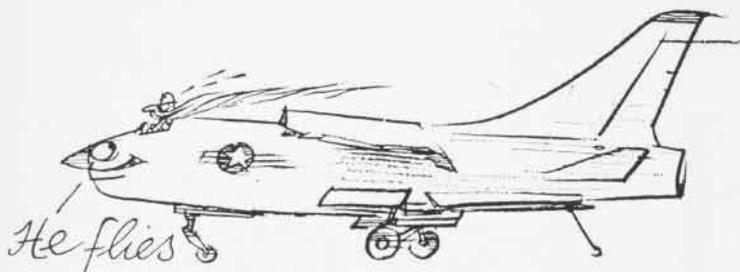
craft revealed that the bolt that connects the starboard hydraulic actuating cylinder to the inboard gear door did not have a cotter key. This allowed that nut to back off, permitting the hydraulic cylinder to only partially activate the gear door. The bolt had been removed and inspected during phase maintenance and replaced without a cotter key.



Grampaw Pettibone says:

Jumpin' Jehosaphat! This reminds me of some prose. "Once a maintenance task is begun, never leave it 'til it's done; be the labor great or small, do it right or not at all." Even though some confusion existed during the phase inspection relating to the subject bolt, the bottom line is that the cotter key was not replaced. This flight crew worked like beavers with the aid of ground support to get out of this booby-trapped situation. It's easy to Monday-morning quarterback but all in all they were deliberate and planned their actions to try and take best advantage of the time and fuel remaining prior to the final approach. Pilots entrust their lives to the maintenance crew. Nuff sed!





He flies

like an old timer!... a regulate grey beard!

Real Sharp

Two F-8A *Crusader* pilots departed a Marine Corps air station on the West Coast for an in-type instrument check flight. Shortly after takeoff, the chase pilot declared an emergency owing to fluctuating oil pressure, and the lead pilot escorted him back to the field. After the chase plane had landed safely, the escort pilot executed a wave-off, cleaned up and headed toward the sea in a climb.

As the aircraft passed through 20,000 feet in burner at .95 indicated Mach, the canopy glass exploded. Fragments of the canopy shattered the pilot's visor, causing a laceration of his right cheek and eye with loss of vision in the right eye.

The pilot immediately observed the effects of wind blast in the cockpit. He quickly realized the canopy had failed, but determined that the aircraft was functioning normally with no indication of smoke or fire. He lowered his seat to prevent accidental wind-blast ejection, reduced speed by coming out of burner and cutting power to idle, dropped the speed brakes and began a normal descent.

A Mayday transmission was made on guard, but the pilot was unable to receive clearly the answering station because of wind-blast noise. He then contacted El Toro tower, gave it his situation and requested a straight-in approach with the crash crew standing by. Approach control requested the pilot to change frequencies for radar control and approved the straight-in approach. The Moresst gear was not available on this 6,300-foot runway,

but the pilot was able to stop the aircraft by cutting power and applying brakes. The overrun chain gear was available but not needed.

The crash crew was waiting for the aircraft when it came to a stop and immediately warned the pilot that the face curtain was partially pulled. After the safety pin was inserted, the crash crew assisted the dazed pilot from the cockpit. The only damage to the aircraft was the broken canopy glass.



Grampaw Pettibone says:

Yipes, how hairy can it get! This lad has got what it takes! Cast-iron guts, brains, and skill are a mighty hard combination to beat. Now here is a lad with less than 600 hours total flight time and only 27 hours in model, yet he handled this emergency like a real old timer.

The board concluded that "he did an incredible job of flying and landing the aircraft on a short runway without arresting gear while beset by extreme physical stresses plus loss of vision in his right eye." Amen. Couldn't have said it better myself.

Makes of Gramps mighty proud to place this youngster's name near the top of the Real Pro Roster. (May 1964)

People Eater

Following a routine night carrier landing, an F-14A was de-armed and

then taxied to its final parking spot slightly forward of the island. The flight deck director signaled for chocks and chains and for the pilot to secure the starboard engine. It was secured and two plane captain trainees began to chain the aircraft down.

As the final tie-down chains were being applied to the nose gear, one of the trainees attempted to get the flight deck director's attention by waving his lighted flashlight. Unable to get the director's immediate attention, the trainee walked forward in a crouched position partially under the port engine nacelle on the tunnel side, waving his flashlight.

With the port engine at idle power, the trainee then stepped in front of the port intake and was immediately ingested head first. The flight deck director saw this and gave the pilot the engine-off signal. The pilot immediately shut down the engine. A flight deck corpsman was called and the ingested plane captain trainee was removed from the intake. He survived the incident.



Grampaw Pettibone says:

Dumb-dumb-dumb! In my day, careless folk walked through props. Nowadays careless men get sucked up by these new fangled air scoopin' machines. FOD comes in all forms, including people. Trainees should not be allowed to wander around the flight deck unsupervised. Flight deck hazards and safety procedures must be continually stressed but more importantly, understood. Dad burn it, aeroplane engines demand respect. Whether you work around piston-pumper, turbo-prop or air-suckin'-type engines, be alert to the hazards and understand the "why" behind procedures. That way we'll see ya around . . .

