



# GRAMPAW PETTIBONE

## Dear Grampaw:

This didn't happen to me but I thought you might like to hear about it. One of the medical officers at our air station—not a flight surgeon—desired a ride in a jet and arranged with a commander on two weeks' active duty in a reserve squadron for a flight in a TV-2. The doctor got down to the flight line in the nick of time and off they went, towing a target sleeve for gunnery by squadron *Congars*.

When he was briefed, the doctor was told that an oxygen mask was unnecessary since they would go only to 15,000 feet and the cabin altitude would never be above 9000 feet. The borrowed hardhat had no lip-mike but this was justified by saying that "so long as you can hear me, it's O.K."

During one of the gunnery runs, the occupants of the TV felt a moderate jolt. The pilot assumed that a 20mm had hit the tow cable or possibly a wing and asked the good doctor to look around for evidence of it. The doc was a bit shook when he noticed a sizable hole in the left wing near the fuselage with fuel streaming behind. The pilot didn't see this and yelled at the doc to get off the controls.

Having heard about an ejection seat, the doctor checked for one in the airplane. He was surprised to find no face curtain, but was unable to ask the pilot about this since he had no mike. Exploring his personal safety gear, he found that the leg straps to his chute were missing. He finally realized that he was sitting on them, but couldn't free them without releasing his safety belt. He was afraid to do this because of the erratic manner in which the plane was behaving. Owing to his confidence in the pilot and the lack of an alternative, he finally leaned back and prayed that his wife wouldn't hear about it.

A safe landing was made and it was found that there was also a 20mm hole in the horizontal stabilizer which had contributed to the difficulty in control experienced by the pilot during flight.



All ended well, but one can't help but wonder why.

LT (MC) USNR



### Grampaw Pettibone Says:

Lesson No. 1 on how to lose friends and alienate tow pilots—shoot a few holes in the towplane. Ordinarily I'm not one to hold a grudge, but when they start lobbing 'em in my direction my blood pressure zooms and friendship ceases.

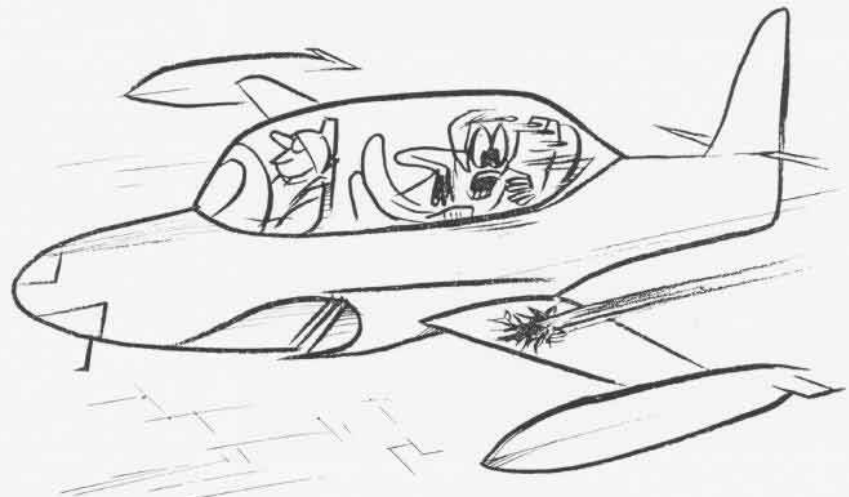
Strictly speaking, the pilot of the TV-2 complied with the broad provisions of

existing OpNav instructions, but that is not to say that he used the old noggin to the fullest extent. The passenger was not required to use oxygen since the intent of paragraph 41.a. of OpNav Instruction 3710.7 is to specify its use above a cabin altitude of 10,000 feet (this will be clarified in the forthcoming revision to that instruction). Of course, that leaves no provision for loss of pressurization.

The previous day the pilot did brief his prospective passenger, but it appears that he may not have adequately instructed him "on such personal safety and survival equipment and procedures as required for the particular aircraft" as required by paragraph 63 of the same instruction. For one thing, the TV doesn't have a face curtain, but the passenger didn't know this and, once airborne, he couldn't question the pilot on this point.

While two-way interphone communication was not required by OpNav directive, its desirability was dictated by common sense—and by near-necessity in this case.

Following the written rules is not always enough. They serve as a general guide, but they should be supplemented by the unwritten rules of common sense, foresight, mature judgment and thoughtful consideration for the other fellow. Don't be like the little fellow who told his mother when she returned to the kitchen: "Well, you didn't say NOT to put the cat in the dishwasher."



Here she is!  
Where do ya want it?



## WHAT'LL I DO NOW?

The following was taken from a message the ferry pilot sent to his Commanding Officer:

F2H-2 BuNo 124956 WHEELS UP LANDING 152200 AT NAS ALAMEDA X NO INJURIES TO PILOT MINOR DAMAGES TO AIRCRAFT X AIRCRAFT FOR DELIVERY TO FASRON X FASRON WILL NOT ACCEPT X REQUEST INSTRUCTIONS X.



*Grandpa Pettibone Says:*

Wish I had a copy of the CO's reply. This red-faced pilot's acute embarrassment could have been avoided by simply placing the gear handle down—prior to landing.

## My Aching Back

After the break for landing, the F2H-2N pilot reduced power to 60% and extended the speed brakes. At 160 knots the wheels and flaps were lowered. At the 180-degree position, with the aircraft at 1300 feet and 140 knots, the speed brakes were retracted. Suddenly the aircraft went into a nose-down attitude, and the pilot was forced to use all his strength—both hands—to free the elevator control. The pilot told the tower he was in trouble and didn't want to go around. At the 90° position, the pilot reduced power, causing the need for more "up" elevator. Both hands were again required to free the stick.

Over the end of the runway, at 120 knots and slightly high, the pilot reduced power. The nose fell through slightly. To aid in bringing the nose up, the pilot extended the speed brakes. This time before he could free the stick the aircraft hit the runway. The starboard main gear, tip tank and nose-wheel struck almost simultaneously. The pilot sustained a back injury; the aircraft was a strike.



*Grandpa Pettibone Says:*

This pilot was dealt a rough set of circumstances that cost an airplane

and an aching back and almost cost a life—all owing to error of other personnel. The pilot had made a complete preflight inspection of the aircraft, including a check for freedom of movement of controls and operation of the trim tabs. Further, no binding of the controls was evident during the 70 minutes prior to his break for landing.

An improperly seated oxygen bottle that stopped elevator control movement was the culprit. A coaxial cable from an outside antenna to special electronics equipment was routed through the hole in which the oxygen bottle is recessed and tilted the bottle upward. It became apparent that the aircraft had been transferred and accepted with the oxygen bottle out of proper position.

The aircraft accident board concluded: (1) The electronics personnel should not have routed the coaxial cable through



Remember  
HIS life  
is in YOUR hands

the stowage space for the oxygen bottle whether or not it was out of position; (2) aviation equipment personnel should have detected and corrected the faulty positioning of the bottle on the acceptance or subsequent routine maintenance checks; and (3) airframes personnel could have noted the chafing of the elevator control tube end against the improperly positioned oxygen bottle if a particular access opening had been removed as required during the last routine inspection.

Aviation safety is an all-hands job that requires teamwork and attention to detail and the conviction that "I AM my brother's keeper." If he had his druthers, a pilot would druther be given a break than a broken back.

## Policy Paid

After an hour and 20 minutes of flight, an SNJ had a momentary overspeeding of the prop followed in rapid sequence by rough engine operation and complete engine failure. Unable to restart the engine, the pilot elected bailout for himself and the rear seat passenger who was on his first aircraft flight.

The passenger pulled his rip cord at 1750 feet. The pilot abandoned the aircraft at about 1000 feet, getting two or three swings of the parachute before landing uninjured in a clear area. The passenger landed in rough, wooded terrain, his parachute becoming entangled between two trees with the wearer left dangling. Several oscillations and minor scratches later, he



freed himself from his 'chute harness, climbed down a tree and again planted his number twelves on solid earth.



*Grandpa Pettibone Says:*

A rough introduction for this newcomer to aviation, but he wasn't up a tree for long. Prior to the flight the pilot had thoroughly briefed his uninitiated passenger, a fellow Marine, on bailout procedures—a policy that pays good dividends for small investments of time.