GRAMPAW PETTIBONE

Dear Grampaw Pettibone:

Looks as though Grampaw read more into—or out of—that accident (captioned "Timber-r-r" in your August column) than originally was written into it. Visions of a big R5D boondoggle, complete with dancing girls, must have gone thru the old man's double-dome head.

How about it, Dad, let's stick to the facts, and just give a good comprehensive analysis of the accidents and leave the conjecture to the pilot's wife.

Seems to me that it is the commanding officer's prerogative as to which fields *his* pilots use for refueling stops.

—LT., USN

Grampaw Pettibone Says:

Son, your old Dad likes your spirit and the way you express yourself, but then there's the story about the kettle that called the pot black. Gramp had merely stated that he was a suspicious cuss and suspected that the pilot or a passenger wanted to be closer to town and thus brought a bunch of troubles on himself when he landed at the civil airfield instead of at NAS DALLAS which was just a few miles away.

As for the CO's prerogative concerning fuel stops, CNO's message 041756Z of September 1957 clearly states a concept of efficient and economical operations which has been recognized by most commands for quite some time.

Power to you for calling 'em as you sees 'em. My old hide's pretty tough and thick, and if nobody threw any barbs, I'd think I was over the hill.

Dear Grampaw Pettibone:

Ref your article (page 6 of June 1957 issue of NAVAL AVIATION NEWS) about the Memphis to Dallas S2F flight. Admittedly, every pilot should conduct a thorough pre-flight inspection before each hop. However, pilots *should* be able to assume servicing and *some* other functions properly performed. If every pilot personally checked everything (gas tanks, oil

tanks, hydraulic tanks, air pressures and a thousand and one others) we would need about twice as many pilots for the present amount of flying.

Why not put the responsibility on the civilian contractor or the station? Whoever heard of leaving gas caps off after fueling? What if it rains? How about sparks from tractors? Is a pilot guilty until proven innocent? Do *you* always check each tank?

—CDR., USNR

Grampaw Pettibone Says:

While stroking my beard over this pilot's plight—
This victim of syphoning gas one night,
Whose plane was fueled by a civil crew
That left his gas cap all askew—
I was sadly reminded of poor Tim O'Shea
Who died defending his right o'way—
Old Tim was dead right as he drove along,
But he's just as dead as if he'd been wrong!

Lassoed Panther

The pilot of an F9F-5 was assigned a routine gunnery tow mission for a group of F2H-3's. During recovery from the nose-high attitude assumed in launching the tow banner, the pilot found he could get no effective elevator movement. Checking the rear view mirror, he noted the cause of the control restriction—the tow line was entangled between the horizontal stabilizer tip and the elevator. He had caught his *Panther* by the tail.

The pilot pickled the switch in order to drop the tow line, but stick movement remained limited to about three inches, even when the pilot used both hands and rocked the stick back and forth in an effort to regain effective control of the airplane.

With his jet in a near-vertical dive, the pilot reported on tactical radio frequency that the tow line was wrapped around the controls and that he might have to eject. In the pilot's words, "The plane did a slow and smooth roll and a half to the left as I was making the radio transmission.

"As I finished the radio transmission, I saw the altimeter pass rapidly through 8000 feet. Remembering that the terrain elevation was about 4000 feet, I placed my feet in the stirrups and pulled the face curtain."

Immediately after ejecting, the pilot reached for the seat belt, but found that he had already been automatically released from the seat. He pulled the D-ring and the parachute opened with a jolt. Said the pilot:

"As soon as the chute opened, I saw the aircraft burning directly below. It had already hit when I looked down. The outer shell of my helmet came off when the chute opened, but the liner and oxygen mask were intact. I saw my helmet and the seat falling below me, and pieces of the canopy, which I had gone through, were falling around me. The ground came up fast; I hit in the soft sand and rolled over backwards.

Grampaw Pettibone Says:

This lad had a purty narrow squeak. He may have been saved by the fact that he had his *Panther's* flaps full down, thus keeping the speed slightly under 300 knots during the downward plunge. And while it's not recommended as normal procedure, in this case he did right in

ejecting through the canopy—with his *Panther* pointed down, speed was of the essence. But he knew that when you gotta go, you gotta go!

The Right Attitude

At 2000 feet with his aircraft afire, the pilot of an F9F-6 prepared to eject. An excerpt from his statement follows:

"The canopy went off very fast, and as I raised my head I noticed the horizon and realized I ought to be in a level flight attitude. *I immediately thought of the chart published by the Safety Center and discussions on raising the nose prior to ejecting,* especially at low altitudes, and noted that I was at 2000 feet making 200 knots.

"I eased the nose up with stick pressure, and at the same time put in some nose-up trim. I immediately put both hands over my head, got hold of the curtain handle and gave it a firm hard pull forward and down. The windblast was mild and I do not remember releasing the face curtain or parting from the seat.

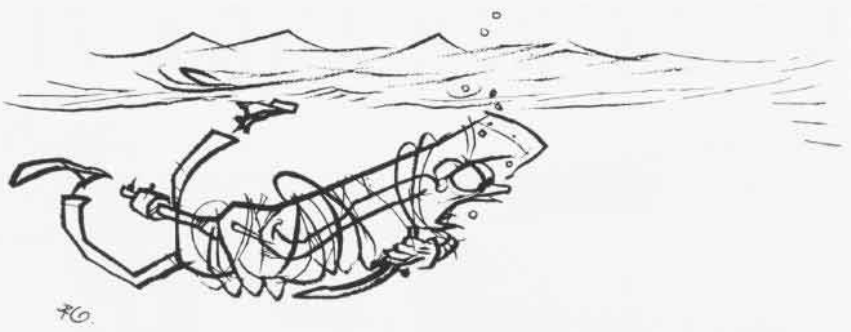
"I realized I was close to the ground and had to get the chute open. For some reason I can't explain, I don't remember seeing anything from the start of the ejection until the chute opened, except for one glance at the ground. I made a fast grab for the D-ring with my right hand and, not finding it, started searching with both hands. I think I grabbed it with my left hand. There was no difficulty in pulling the D-ring out after I found it.

"Helo pickup was made in minutes."

Grampaw Pettibone Says:

This lad was able to save himself because he remembered that the right attitude can spell the difference in a low altitude ejection. While he had the advantage of an automatic lap belt, he knew he had to rely on manual actuation of his parachute. The pilot had a few bad seconds when he couldn't find the D-ring which was apparently dangling out of its slot on the harness. Except for the Cougar's nose-up attitude at ejection, the delay could have been fatal.

The pilot realized afterward that he could have added a little more gravy by holding that nose-up attitude long enough to convert his remaining excess airspeed into precious altitude.



Whip Splash

The HUP-2 pilot (lieutenant commander) had established a hover over an AVR preparatory to transferring a passenger (chief warrant officer) to the ship's deck. The ship was rolling and pitching moderately, and, as the crewman (a commander and fellow helicopter pilot) informed the pilot that the passenger had landed on the deck, the pilot lost sight of the AVR's radio antenna. Relative movement between the AVR and the helicopter at this moment caused one of the main rotor blades to strike the whip antenna.

Following the collision, the pilot moved the helicopter clear of the AVR and decreased his altitude to put the man in the hoist sling in the water. As intense vibration existed, he elected to ditch while still maintaining some measure of control. On contact with the water, the pilot applied right cyclic to force the rotors into the water and facilitate evacuating the aircraft out the port side.

The CWO abandoned the hoist sling as the helicopter ditched, remained under water for a few seconds to avoid flying debris, and inflated his Mae West.

The commander who had been operating the hoist fared less well. He appeared on the surface momentarily, and then was pulled under by the helicopter as it sank. He had not removed the HRS crewman belt which was secured to an eye on the side of the port main hatch, permitting the user to move approximately four feet from that point. As the commander was pulled beneath the surface, he attempted to remove the belt. However, it incorporates a safety device to prevent inadvertent release, and he was unable to operate it because he was wearing gloves. Furthermore, because he was under water, it was impossible for him to see what he was doing.

"I distinctly recall thinking, 'So this is how I'm going to die,'" he said. "Vaguely I remember reaching for my knife, jamming it under the belt, and taking one cutting stroke with it. This knife was a machete type, about 12 inches long, which I have carried since 1943. Fortunately, it was both sturdy and sharp.

"Personnel on the AVR tell me that when I floated to the surface, my Mae West bottles had been actuated and I still had the knife in my hand. The next thing I clearly recall is the sight of a small section of gray deck directly under my face and wondering who had done all the vomiting."

The aircraft accident board attributed the accident to the pilot's failure to evaluate properly the hazard of collision in hovering over the AVR under the existing sea conditions with a secondary factor being the rough sea which caused the AVR to pitch and roll with resultant extensive movement of the whip antenna. The board recommended that personnel transfers from helicopters to small vessels be attempted only under emergency conditions when the sea state is moderate or heavy and that every chopper pilot and crewman be required to carry, attached to his flight clothing, a sharp knife of sufficient size to be of use in emergencies.

The pilot believed the accident could have been prevented had he maintained sufficient clearance from the antenna or if he had aborted the mission more positively with added power and left cyclic when he lost sight of the antenna. However, he felt that the latter action at the most critical point in the transfer would have resulted in injury to the man in the sling.

Grampaw Pettibone Says:

Well, fellows, an eye on the whip could have spared the dip.