GRAMPAW PETTIBONE

Command Supervision

The following comments, made recently by the Senior Member of an Area Safety Council, point up the responsibility and capability of a squadron commanding officer in improving the safety of aircraft operations.

Safety in Naval Aviation has many facets and many technical areas, but there is one particular all-encompassing area that is fully as important as any other—*Command Supervision*. There is direct correlation between the attitude of the commanding officer and his unit's safety record, and, in the absence of information to the contrary, a deteriorating aviation safety record must be viewed as a breakdown of supervision from the top.

For example, one squadron operated for more than a year, including four months on deployment without an accident, and then with a change of command had eight accidents in one year. Then, subsequent to another change of command, this unit showed a steady and marked improvement in its accident rate.

In another case, a new commanding officer was able to reduce his squadron's accident rate to 27% of what it had been for the previous year.

Two AD *Skyraider* squadrons with long histories of trouble-free engine operations were visited by teams from the Naval Aviation Safety Center to determine the salient features that made these squadrons different from others. Among their conclusions were the following:

1. The squadron commander was very experienced and provided strong, positive leadership.

2. The commanding officer was vitally interested in safety of aircraft operations and every man in the squadron knew he was interested.

Seldom is supervisory error cited as a cause factor, but frequently it is only necessary to scratch the surface lightly to see a lack of supervision in the background.

Flight and ground safety is an essential element of good operating practice and is, therefore, a command function which must be given the utmost consideration at all times. Success in the accomplishment of our mission in Naval Aviation is not compatible with aircraft accidents, and accident prevention is a normal part of command duties. Whereas the need for close supervision of air operations is obvious, the need for more and better supervision of an effective ground program in aviation safety is increasing. Supervisory efficiency must be judged as much by accident prevention efforts as by other standards.

A properly planned operation, executed effectively, is inherently safe. A command's accident record is an indication of the effectiveness and efficiency of its commander.

Grampaw Pettibone Says:

Mighty well said! These remarks should help everyone see that there's no vision like supervision.

Squeeze Play

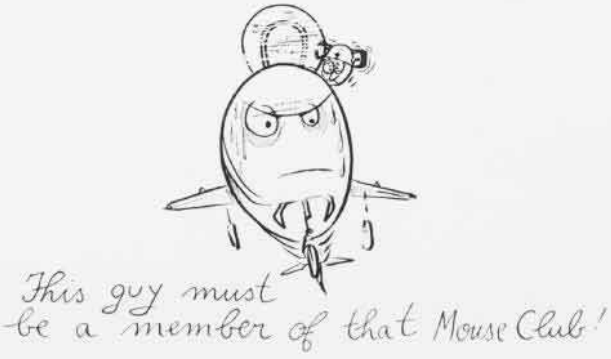
While taxiing to the runway for takeoff, the leader of a division of *Cougars* turned to look over his right shoulder at the remainder of his division, at the same time placing his left hand on what he thought was the glareshield. Instead, he rested his hand on the windshield frame.

The pilot had started closing the canopy prior to looking back to his division. The leading edge of the canopy frame caught his gloved fingers, whereupon he jerked his hand free, informed the tower that he had been injured, and returned to the line where he was met by an ambulance.

Grounding for an estimated six weeks resulted from the injury sustained—amputation of the tip of the right ring finger and simple fracture of the middle finger.

Grampaw Pettibone Says:

Ouch! This happened to a 5500-hour man with 120 hours in model, which proves that most anyone can get caught in the squeeze and getting caught can be really serious.



Fog in the Cockpit

An F9F-6 in final approach for landing came over the boundary fence in a nose-high attitude. The attempted flare-out resulted in an increased rate of sink and the *Cougar* slammed down hard. The pilot was uninjured, but his airplane fared less well.

The cause of the pilot's difficulties was his attempt to land his *Cougar* while flying blind. His failure to turn up the temperature control caused condensation at low altitude, and the windshield fogged over. In spite of the lack of forward visibility, the pilot continued his approach, attempting to see around the windshield by opening the canopy. However, he didn't have his goggles in place over his eyes and the wind blast forced them over his helmet. For the remainder of the approach, the wind blast caused the goggles to administer a series of rabbit punches in the back.

Peering around the edge of the windshield, the pilot wasn't aware of the *Cougar's* cocked-up attitude.

The aircraft accident board concluded that the primary cause of the accident was the pilot's improper letdown technique and his failure to take corrective action to preclude the fogging of the windshield. A secondary factor was the over-rotation of the aircraft, causing a high rate of sink, caused by the pilot's preoccupation with his lack of forward visibility.

The board recommended that a refresher lecture on proper use of cabin temperature be given to all pilots and that pilots review proper wearing of H-4 helmets with goggles.

Grampaw Pettibone Says:

Seems to me that those goggles beating you between the shoulder blades should have driven home the idea that there was an easier—and safer—way of doing things. And that windstream musta caused quite a bit of eyeball sweat.

Since you had plenty of go-juice for a go-around, you could have saved yourself and your jetbuggy a beating by taking a waveoff when the windshield first fogged over, allowing time for clearing out the cockpit fog, thus making possible a less hairy landing.

Of Life and Limb

An FJ-3 *Fury* at altitude above clouds over Japan had a flameout. The pilot was instructed to eject. He spotted Atsugi through breaks in the clouds and decided to make a flame-out approach to the Naval Air Station. He descended at high speed, misjudged his approach and crash landed off the field. He was killed, the plane was a strike.

Another *Fury* flamed out at altitude in the same area during clear weather conditions. The pilot elected to make a flame-out approach to NAS ATSUGI. He approached fast and caught the arresting gear cable. The cable parted, and the aircraft continued off the runway. There was minor damage to the aircraft and no injury to the pilot.

Grampaw Pettibone Says:

The first pilot sacrificed his life through failure to heed the on-the-spot advice to eject and the following life-saving information contained in paragraph 4.e. of OpNav Instruction 3750.12: "Normally a flame-out approach should be attempted only during daylight hours and when the approach from the high key position can be made clear of clouds with sufficient visibility to keep the field in sight."

His motives were commendable, but he crawled out on a limb when he tried to save his jet job. Familiarity with the data given in the aforementioned instruction is a *must* if the right decision is to be made at the right time. Like the man on that tellyvision contraption says, "This is *your* life!"

Understatement of the Month

"I don't know what caused this accident but it appears that I retracted the gear prematurely and flew into a slight upgrade in the field. If so, this accident could have been prevented by conforming to local course rules which require 100 feet of altitude for gear retraction."

Something Concrete

At a recent Area Safety Council meeting, it was explained that undershooting at the local Navy airfield might prove dangerous or at least hard on tires since erosion and heavy rainfall had left a three to four-inch edge or lip on the ends of the runway. It was stated that repairs were planned, but all units should be warned to be careful of undershooting at the present time.

Grampaw Pettibone Says:

Let's get those repairs out of the planning stage and do something *concrete!* Otherwise those stiff upper lips on the runways will account for a lot of undercarriages coming unglued. With potholes in the runway threshold, the safety record's soon shot to pot—and that's no welcome matter!