



# GRAMPAW PETTIBONE

## Caught Flat-Footed

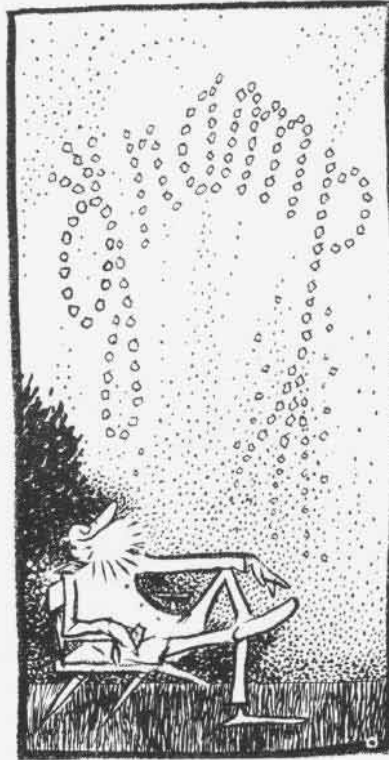
An R5D on an IFR clearance to Wake Island made a normal takeoff from an Okinawan base, using 15 degrees of flaps. The gear was retracted when a safe landing could no longer be made on the runway. An altitude of 100 feet and an airspeed of 115-120 knots had been attained when the crew chief reported that the number four engine was on fire.

Saying "We're going to belly in," the plane commander immediately chopped the throttles, pulled the props full back and cut the ignition to all engines. As the aircraft approached the ground, the pilot realized that he was going to hit the side of a hill. He called for full flaps, pulled back on the yoke, and put the aircraft into an extremely nose-high attitude, just missing a deep ravine and barely clearing a ridge. After initial impact the airplane bounced back into the air, then on final impact the fuselage split just aft of the crew's compartment, the wing tanks ruptured, the cargo doors opened, spilled gasoline caught fire.

Two minutes after final impact all 31 occupants had evacuated the burning airplane. The copilot went out his side window, closely followed by the cut and bleeding pilot who had sustained minor facial injuries. *Neither pilot had used shoulder harness during the takeoff.*

The accident board concluded that the pilot erred in judgment by electing to crash-land the airplane following discovery of the engine fire since there was sufficient altitude and airspeed for satisfactorily clearing the surrounding terrain on three engines and subsequently landing on the runway. The firewall shut-off valve to the number four engine should have been pulled regardless of the subsequent actions on the part of the pilots. The fire in the engine would probably have been extinguished had the firewall shut-off valve been pulled and the fire extinguisher system activated.

The board recommended that all



transport pilots be thoroughly schooled on the procedures to be followed in case of fire aboard multi-engine aircraft and that it be insured that they understand the performance characteristics of their aircraft under all flight conditions and configurations before being designated plane commanders.



*Grampaw Pettibone Says:*

Great Balls of Fire! This lad gets an engine fire in one of his



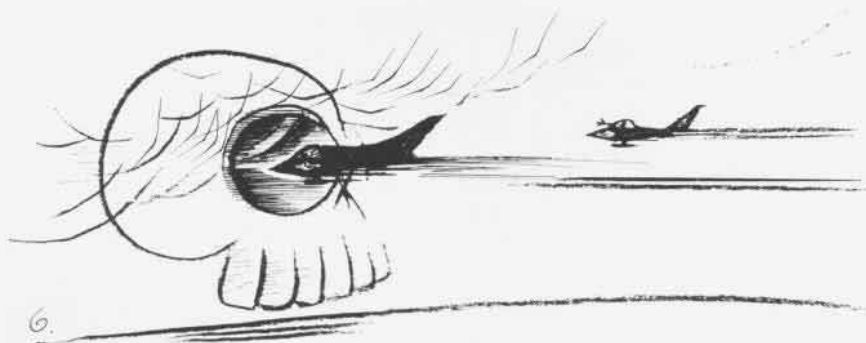
four engines and without further evaluation of the situation chops off all engines and makes a crash-landing in rough terrain. It appears to me he had a complete blackout of his think-in' box. He didn't even have the presence of mind to actuate the firewall shut-off valve. And the copilot visually checked the fire *only one time* and then neglected to actuate the fire extinguishing system.

When asked why the engine shut-off valve was not closed to the number four engine, the copilot said he didn't have time and he was concentrating on shutting down all engines prior to landing. This reminds me of the lad who landed with his gear up because the sound of that durned gear warning horn at such a critical point in his landing approach was so blantly-blank distracting.

It's just plain miraculous that this fiasco didn't result in a multi-fatality tragedy. One passenger died three days after the accident, the others sustained only minor injuries.

The plane commander had 5500 flight hours, the copilot 4100. When gents with this kind of experience are caught this flat-footed, I'm really shook. They had long years of accident-free flying, but they lacked clear emergency thinking in the pinch. Only frequent training in simulated emergency conditions can prick that complacency bubble and keep a pilot on his toes and ready for the real McCoy.

Another thing, I'm getting mighty dad-burned tired of reading about pilots who refuse to recognize that shoulder harnesses were put in aircraft for a reason—to be used. There's absolutely no reason for their use not being SOP. OPNAV Instruction 3710.7A's wording leaves no doubt about it: "Each person's safety belt and shoulder harness shall be worn and tightened prior to takeoff and shall be continued in use until the completion of the flight, except when necessary activities require temporary removal." This durned well includes multi-fan transport-type drivers!



## Led Astray

TWO A4D-1 *Skyhawks* departed Cecil Field one afternoon on the final leg of a low level navigation flight from Guantanamo Bay, Cuba, to NAS OCEANA, Virginia.

The flight proceeded normally at an altitude of 500 feet until approximately 54 minutes after take-off when the ceiling lowered to 1000 feet in light rain. Twelve minutes later the weather deteriorated, and the chase pilot closed to a tight wing position to maintain contact with the flight leader. When the ceiling reduced to 150-300 feet with rain, visual contact between the two pilots was lost and the wingman slowed his aircraft to assure safe separation. Shortly thereafter, in the vicinity of Edenton, North Carolina, while flying at an indicated altitude of 100 feet and an airspeed of 320 knots, the wingman's *Skyhawk* flew head-on into a flock of large birds, a number of which struck the aircraft.

The cockpit filled with smoke and, as the pilot reached to turn off his pressurization, the aircraft struck an unknown object, possibly a ground obstruction. The density of the cockpit smoke increased, completely obscuring the instruments. The pilot added full throttle, pulled back on the stick, climbed into the overcast, and ejected at an altitude of about 2000 feet. He came down uninjured in a field; his aircraft crashed into a swamp.

After the two aircraft had become separated, the flight leader had climbed into the overcast, oriented himself on instruments, and contacted NAS OCEANA. He requested an instrument approach, utilized UHF direction finder steers, and broke out of the overcast a few miles short of Oceana.

At the time the flight first encountered weather significantly different from that forecast, both aircraft had sufficient fuel to proceed to sev-

eral suitable airfields. When the weather markedly deteriorated in North Carolina, the flight was only 40 miles from MCAS CHERRY POINT where VFR conditions prevailed.

Prior to their departure from Cuba, the squadron commanding officer instructed both pilots that they should not make the flight unless the ceiling was above 2000 feet and the visibility considerably better than VFR minimums of three miles.



### Grampaw Pettibone Says:

This kind of shenanigans makes me burn! The pilots risked their own lives and there's no telling how many others when their jets zoomed through the soup on a VFR clearance. Also, it durned well should have become crystal clear sometime before they hit the 150-foot ceiling and near-zero visibility that they were directly violating their CO's briefing instructions.

I've no quarrel with the junior birdman for pulling up and ejecting once he plowed into the flock of birds which were also flying at 100 feet in an effort to stay below the overcast, but the situation should never have deteriorated to this.

The flight leader, a lieutenant commander, should have canceled out the sandblower flight and diverted to Cherry Point. The wingman, a relatively inexperienced Ltjg, might well have shown enough good sense and spunk to recommend this, but it's understandable why he would rely on his leader's judgment and thus be led astray. But he still should have refused to fly formation before the weather became so bad that, in his own words, "I was more afraid of making a 180-degree turn at such a low altitude in the present visibility than I was of continuing to a briefed

known destination."

The more I think about it the more convinced I am that both of these boys should be horse-whipped for thundering along at 100 feet and 300-plus knots in weather conditions so bad they lost each other! And the flight leader deserves some extra lashes!!

In view of the rain and ceiling conditions reported before take-off and the warm front along the route, it should have been evident that weather would have to be closely monitored in flight. Times have changed since the days when you could start down a muddy rutty road in an old Model T with reasonable assurance that you could back out again or bull your way through the mudholes. Safe operation of today's fast jets demands that canned decisions, some "what'll I do if this happens," be completed before the aircraft ever leave the runway.

## Dear Grampaw Pettibone:

Come, come, Grampaw! Ever since reading the item "Squeeze Play" in your January issue, I have been waiting to see some further explanation of how the poor fellow lost part of his *right* ring finger through his indiscretion in resting his *left* hand on the windshield frame while closing his canopy on takeoff. Nary a word of enlightenment have I seen! Can it be that Grampaw pulls bloopers just like his unfortunate clients, or are there mysterious hazards to an aircraft cockpit that are beyond my 1100 ken?

Of course my *real* reason for writing this is to prove to you that surface sailors (even old fogies [he said it, I didn't—Gramps] of RAdms.) do read Naval Aviation News and your column—and gain thereby, I might add, much of interest and professional enlightenment.

—Rear Admiral, U. S. Navy



### Grampaw Pettibone Says:

My first impulse was to say this was the first mistake I ever made, but I've already used that line. My second impulse was to comment thusly, "One thing's fer shure, it warn't easy!" But after mulling the problem over for awhile it became purty obvious that this lad was so shook by events that he had the wrong fingertip amputated.