GRAMPAW PETTIBONE

Sad Selection

A water survival-helicopter rescue training exercise was being conducted just off the West Coast, using a CH-19E as the rescue aircraft. The crew was composed of an experienced, well qualified pilot (right seat) and an observer in the left seat flying in this capacity for the first time. In fact, this was the first month the observer had been placed on the non-crew member flight list.

The helicopter's mission was to pick up personnel in the water and discharge them ashore. After the sixth "pickup," the forward fuel warning light came on. After landing to discharge personnel, the pilot changed the fuel selector to the aft tank. He experienced extreme difficulty in turning the selector but was able to do so. This difficulty was discussed with the hoist operator, a member of the maintenance crew. It was decided to check the selector when they returned for fuel.

The crew continued the exercise. After a reasonable time, the warning light for the aft tank came on. As the pilot had experienced difficulty in operating the fuel selector previously, he instructed the non-crew member observer in the left seat to change tanks for him when they landed to discharge personnel.

Upon landing the observer started to move the fuel selector. The pilot told him not to go through the OFF position when selecting a different tank. About this time, the pilot's attention was distracted by activities outside of the aircraft. The observer, who was accomplishing the critical task of selecting a different fuel tank *for the first time,* experienced difficulty in

understanding the instructions because of static in the ICS. He heard the word OFF and, although it didn't seem just right, he turned the fuel selector to the OFF position.

The pilot was concerned with other things and, after receiving an "all clear," added takeoff power and lifted. At an altitude of approximately 15 feet and a forward speed of 30 knots, the engine quit. The pilot immediately split the needles, initiated an auto rotation and landed the helo on a macadam road in an upright position. The main roto blade severed the tail pylon, causing substantial damage. The crew abandoned the aircraft uninjured.

Grampaw Pettibone says:

Holy mackerel! Now doesn't a thing like this really frost you? Here is a pilot with much time in a bird—maybe too much, if experience breeds this kind of over-confidence. It's just plain difficult to see how a guy can utterly disregard that "check-off list" and trust a lad on his first flight to select the fuel. A stunt like this has no place in this business we're in, and the files are full of statistics to prove it. Failure to use the *check-off* list is like gambling with loaded dice—you can't win.

Delayed, Diverted, Drenched

An RF-8A pilot was aboard a carrier off the East Coast for refresher landings. Squadron aircraft were to be flown out from the beach, and he was to switch places with one of the incoming pilots when he had finished qualifying. The pilot needed refresher landings before beginning regular flight operations the following day. For varied reasons, there were delays in attempting to accomplish the landings. Delays encountered were about as follows:

1400—Pilot donned flight gear waiting for squadron aircraft to arrive.

1510—Aircraft landed and pilot waited 40 minutes before he could man the assigned aircraft.

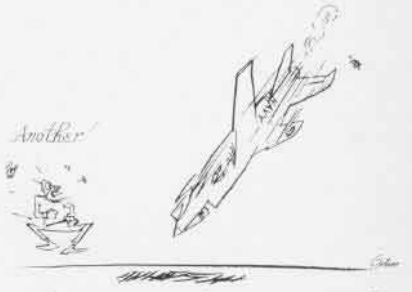
1550—Flight cancelled; pilot returned to ready room and undressed.

1600—Donned flight gear, waited for call to man aircraft.

1700—Undressed and started for wardroom when he was called to man his aircraft.

1800—Manned assigned aircraft and fired up. Fuel aboard 3600 pounds.

1825—Launched with 3000 pounds.



After making three traps in five approaches, the pilot assumed his refresher landings were complete. While he was being taxied onto the starboard catapult, however, information was transmitted that he was being diverted to home base. He failed to receive the transmission owing to radio failure. His TACAN had also failed, but he did not notify the ship.

At 1846 the aircraft was launched for the beach with 1800 pounds of fuel, no radio and no TACAN. After realizing his radio had failed, the pilot rocked his wings, turning down wind to indicate the failure to the ship. He received a bingo and "good-bye" from

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the LSO and headed in the general direction of the beach using bingo information that was nearly four hours old.

By the time he was squared away on a westerly heading his fuel gauge read 1500 pounds. Optimum altitude for a 120-mile divert would have been 30,000 feet, but owing to a cloud layer at 3000 feet and no navigational aids, the pilot elected to remain below the clouds. He departed with old bingo information of 259°/90 NM vice 278°/124 MN, actual bingo data at time of departure.

The first lights the pilot saw were at St. Augustine. Then he saw lights from Jacksonville Beach. At this time the fuel gauge read 700 pounds, but he figured he had only 400 pounds. The pilot pulled the EEP to insure adequate control of the aircraft in case of flameout and immediately heard a side tone on the radio. He contacted Mayport tower and informed them of his situation. Shortly thereafter the engine flamed out and the pilot ejected. All safety and survival equipment operated as advertised and a helo was overhead for rescue in approximately 30 minutes.

Grampaw Pettibone says:

Great horned toadies! It sure took a bag full of unusual circumstances, varied equipment failures, decisions based on incomplete or unknown information and lack of coordination to set this one up. Divert information should be fed to pilots during carquals, but there is certainly nothing against a pilot's asking for it if he hasn't received it. This is a perfect example of how a seemingly innocent but uninterrupted chain of events can lead to the loss of extremely valuable equipment and/or personnel.

Cross Country Nightmare

A DB-26J departed a West Coast air station late one Friday afternoon with a crew consisting of a pilot, safety-observer and three passengers. The pilot filed an IFR flight plan to Clinton-Sherman AF Base requesting an en route altitude of 9000 feet.

The flight departed at approximately 1700 and proceeded normally to Phoenix, at which point the altitude was increased to 13,000 feet. Between Phoenix and Tucumcari, actual instrument conditions were encountered. No instrument lights were available except a console-mounted light and the pilot did not have an oxygen mask. Flashlights were used to replace the inoperative instrument lights and the safety-observer shared his mask with the pilot.

The flight landed at Clinton-Sherman at approximately 2100 to refuel, discharge one of the passengers and repair the instrument lights. A VFR flight plan was filed for Olathe. An intermediate stop at the pilot's home town was included in the planned VFR flight to NAS OLATHE.

The flight proceeded uneventfully to the en route stop where the pilot attempted to establish radio contact. After several unsuccessful atempts, he decided to land without radio contact. The pilot circled the field several times, then set up an approach for the lighted runway.

The approach was normal with a rather hard touchdown. Immediately after touchdown, the aircraft began to yaw and the pilot added power and again became airborne. Because of the explosive noise heard during touchdown and the pronounced yaw, the crew checked the aircraft upon regaining altitude. The pilot was amazed to discover the port main gear and part of the port engine nacelle gone. The crewmen reported a bad hydraulic leak in the aft station.

An immediate heading was established for Olathe with the intention of landing on a foamed runway. Upon arrival at Olathe, the damage to the aircraft was confirmed by tower and crash crew personnel using Aldis lamps. The pilot cycled the gear several times in an effort to retract the starboard main gear and nose gear but was unsuccessful. The nose gear trailed with the wheel 90° to the aircraft. The starboard remained down and locked.

The decision was then made to abandon the aircraft rather than try to land it and a suitable area was requested from the controlling agency. An area was assigned by Air Sea Rescue Headquarters and the aircraft vectored to the bail-out area.

The crew abandoned the aircraft one at a time on successive passes from an altitude of 10,000 feet. All bailouts were successful. The aircraft exploded and disintegrated on impact in an open field—a total loss.

Grampaw Pettibone says:

Great heavenly days! If a fiasco like this wouldn't wilt a lily, nothin' would. An experienced pilot on a night flight at 13,000 feet without an oxygen mask is really asking for trouble. Now this lad must have had some misgivings concerning the en route stop at his home town airport. However, he elected to attempt a night landing at a strange field without radio contact which precluded getting a current altimeter setting. Now that's really askin' for it.

Reportin' and controllin' custodians approve cross-country training flights for just that purpose—training. They expect the flight to be flown as requested unless an emergency situation is encountered. To do otherwise is not shootin' square.

Things could have been a lot more serious without the able assistance of NAS Olathe, Area Air Sea Rescue and Air Force crash/rescue personnel.