GRAMPAW PETTIBONE

And Then There Was One

An F-4J *Phantom II* and an A-4E *Skyhawk* launched from a West Coast air station on a two-plane, day syllabus tactics flight. The F-4 was piloted by a lieutenant (fleet replacement pilot) with an instructor RIO in the rear seat. An instructor pilot was flying the *Skyhawk*.

The two aircraft proceeded to the tactics area—over water adjacent to the coast. During tactics maneuvering, the RIO noted his pilot was having difficulty keeping visual contact with the other aircraft.

While the pilot was maneuvering his *Phantom* at 20,000 feet (with the aircraft decelerating through 400 knots), and twisting around in the cockpit to retain—or regain—visual contact, the forward canopy left the aircraft.

The instructor RIO experienced rapid decompression and sudden severe windblast. He couldn't see the pilot or contact him on ICS. He surmised the pilot had ejected. Thinking he was alone in the aircraft, the RIO ejected, using the lower ejection handle. The ejection worked as advertised, and he was picked up by helo and returned to base uninjured.

The *Phantom* pilot made an uneventful return to home base—minus his forward canopy and his RIO. Investigation indicated inadvertent actuation of the front canopy handle, probably by a pencil or pen in the shoulder pocket of the pilot's flight suit.

Grampaw Pettibone says:

Sufferin' catfish! Seems to me that this RIO was in a heck of a hurry to get out of his machine. At 20,000 feet in controlled flight, this lad should'a taken stock of things before assuming the driver had ejected. That pilot and everyone in his unit ought'a "read and heed" all the information put out by the Safety Center on pencils/pens in the shoulder pocket of F-4 drivers' flight suits. One recent Safety Center publication recommended a "fix" in the form of a flap over that pocket. Good idea.

Come on lads, let's do more than *file* our safety publications!

The Setup

Following flight planning and briefing, a lieutenant junior grade instructor and his ensign student manned their TF-9J *Cougar* for a cross-country to NAS Gulf Coast. Preflight, takeoff and climb to altitude were without incident. Airborne over another NAS, the pilot contacted destination Metro and received the weather as 300 feet obscured, one-half mile visibility in heavy thunderstorms—with no immediate improvement forecast.

The instructor decided to land at the NAS he had just passed and wait for improved weather at his destination. The landing, on a wet runway with a crosswind, was uneventful. Following refueling and about a two-hour delay, the instructor and student again made an uneventful departure for NAS Gulf Coast, where the weather had improved. Since the flight was of relatively short duration, the pilot held his wing transfer of fuel, hoping to dump fuel at his destination.

The *Cougar* entered GCA and began dumping while in VFR conditions. Turning base leg, the internal fuel was at 4,000 pounds; so, the pilot requested a 360° in order to burn up more fuel, also requested braking action from the GCA controller. GCA, after checking with the tower, reported there were no reports but that the runway was "fairly dry." The fuel was still at 3,500 pounds as they turned into final.

The student flew the GCA approach and the instructor took over at one and one-half miles. The landing was on speed followed by aerodynamic braking and use of wheel brakes, at which time the aircraft skidded. The instructor dropped his hook, preparing for a long field arrestment if it proved necessary, while continuing what he described as light brakes. At this time, the port tire blew and the aircraft drifted left— the right brake and rudder had no effect. The aircraft left the runway. The port mainmount of the *Cougar* struck the arresting gear housing, collapsing the port main gear, and the aircraft came to rest 50 yards from the edge of the runway. The uninjured pilots exited their damaged aircraft.

Investigation revealed that, although within limits, the aircraft was very near gross landing weight. And there were puddles of water on the runway.

Grampaw Pettibone says:

Holy mackerel! What the heck kind of a report is "fairly dry" — does it mean "partially wet"? I can't get upset at this lad who initially displayed some darn good judgment in diverting to another field and waiting for better weather. But I can't understand how we allow personnel to lull our pilots into complacency. There is something lacking in the training and supervision of a tower operator who puts out "bum dope" — on runway conditions, particularly when it contributes to an accident. This brings up a number of questions: Where was the tower supervisor? Why wasn't the tower operator *aware* of runway con-

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ditions? Who is responsible for keeping the tower informed? the operations officer? the OOD? Can this situation exist at your NAS? Check it out! It takes everyone's cooperation to make a safe flight!

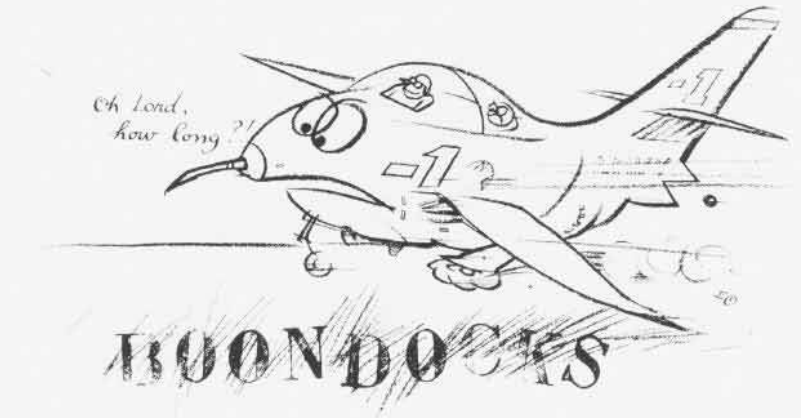
Would You Believe VFR?

The lieutenant ferry pilot was delivering a UH-1N *Huey* from NAS Midwest to NAS Atlantic Coast. During one of his en route stops, a phone call home revealed a close relative was in the hospital, so he decided to RON at a civilian field—in order to visit the sick relative.

Following the visit and six hours' sleep, he and his enlisted crew member arose at 0630, ate breakfast and arrived back at the field at 0710. The pilot conducted a preflight and completed a VFR flight plan to his ultimate destination with an en route fuel stop.

He obtained his weather brief, via the radio of a Cessna 150 on the deck, by contacting the flight service station approximately 35 miles away. The airport manager estimated the weather at the field as 200 feet scattered, 400 feet broken and one to two miles' visibility. (This was substantiated by a pilot report ten minutes after the *Huey* took off.) The poorest weather forecast for the route was for a station 20 miles away which was forecasting 800 feet overcast, visibility two miles with light rain and fog; occasionally 400 overcast, visibility one mile in light rain and fog.

The lieutenant and crew member manned the aircraft, conducted pretakeoff checks and departed VFR at 0815. The *Huey* climbed to 500 feet on an easterly heading. When approximately ten miles out, the pilot spotted a low cloud layer and descended to 300 feet AGL in order to stay VFR. After passing under the clouds he climbed to 500 feet again. About 15 miles out, another low cloud layer appeared, and the pilot descended to 200 feet AGL and slowed to 80 knots. At this time, the helo entered IFR conditions. (There was a five-degree disparity between the pilot and copilot attitude gyro.) At 200 feet, the pilot, now suffering from an extreme case of vertigo, descended again, attempting to regain VFR conditions. The crew member saw that the aircraft was rapidly approaching the trees and told the pilot of the impending ground contact. He immediately initiated a high flare, which decreased his forward speed. The aircraft gained a five-to-ten-knot aft motion and hit the trees, tearing off 15 feet of the tail boom and coming to rest on a heading of 300°, 30° left wing down, four feet off the ground, and supported by trees and vines. The uninjured crew left the aircraft as a small fire developed in the aft section. An outside witness notified the local fire department; the pilot and crew member were examined at a local hospital and released.



Grampaw Pettibone says:

Dad blasted! In spite of all the "tales of woe" we have seen about aviators trying to sneak under the weather — they are still doing it! With the type of weather existing and forecast, it was sheer stupidity — of the highest order — to attempt this flight VFR.

In addition, this lad, knowin' that he was going to be flyin' at minimum altitude on this trip, didn't even bother to write down terrain heights or clearances on his preflight card! I don't believe it!! This pilot's instrument experience compares with the least I've ever seen for a gent of his seniority level! To top it off, his unit issued him an instrument card — when he hadn't met even the minimums. (Sounds like a supervisory problem.) And one gent tried to alibi that by pointing out the number of night helo combat hours the pilot had! I sure don't remember anything in 3710.7F about nighttime substituting for instrument time. If the fellas who set up this instrument requirement felt there was a correlation between nighttime and instrument time, I guess it would'a been mentioned in the General NATOPS. The instrument time required in OpNavInst. 3710.7F is a *minimum*, and every aviator should have more, but at least, that!

There were just too many things wrong with this whole fiasco. And, in addition to pilot factors and supervisory problems, the pilot had a medical problem. Goes ta show ya. Accidents don't just happen, they are caused!