grampaw pettibone

The AWOL Bomb

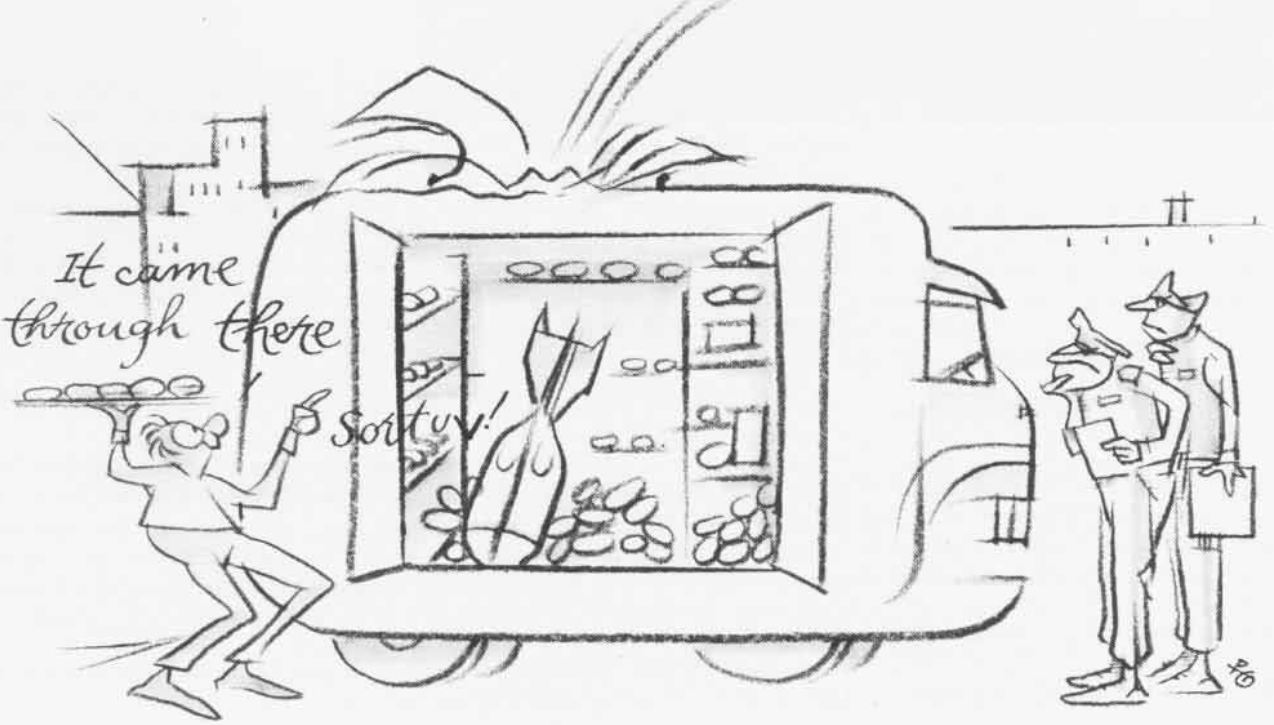
About 0830 one morning a practice bomb (Mk76) was found downtown, USA, inside an English muffin delivery truck belonging to a local bakery. Military ordnance personnel were quickly dispatched to investigate. They determined that the bomb was inert. The truck's roof was extensively torn where the bomb was reported to have entered. (A damage assessment to English muffins was not readily available.)

The muffin man refused to release the bomb to naval personnel because he needed it for insurance purposes. The identification numbers of the bomb were noted but could not be matched with any "lot" numbers assigned to nearby military bases. Local military and FAA authorities investigated all possible aircraft which could have dropped the bomb – without success. Further investigation traced the bomb to its home base which was over 500 miles away. No connection could be made between the subject Mk76 and any aircraft.

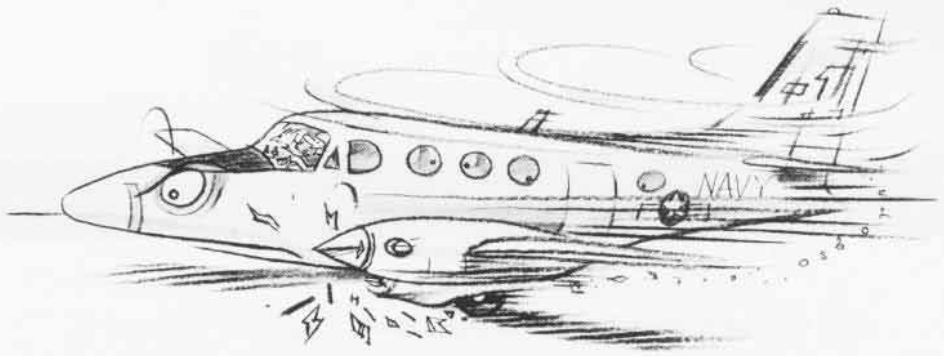
Grampaw Pettibone says:

Holy bomb squad! Looks like a clear case of muffin' up! You could easily leap to the wrong conclusion on this one. Downtown yet! Well, some good investigating shed light on the mystery of whodunit – and it wasn't an airplane. Allegedly, a young lad who was AWOL from the service and driving the muffin truck had misappropriated a practice Mk76. He had accidentally torn the truck's roof when he drove under an overhanging tree branch. He returned the vehicle without reporting the damage. Next time the truck was used, a different driver discovered the hole and found the Mk76 in the back. Understandably, the owner concluded that the bomb was dropped by an airplane.

Sometimes, what seems obvious at the outset disintegrates in the face of evidence. In this case, an airplane didn't assault English muffins. Nuff sed!



ILLUSTRATED BY Osborne



Flop Hop

Following a routine student flight briefing and preflight, a T-44 with two students and one instructor aboard departed NAS Home Plate on an IFR flight plan. The mission was to conduct multiple training instrument approaches at nearby airports. The first three approaches (VOR, ILS, ADF) were performed by the first student at airport #1 and resulted in two uneventful touch and go landings and one wave-off. The instructor then requested and received radar vectors to airport #2 where another approach and uneventful touch and go landing were made.

The aircraft proceeded to airport #3 and completed a routine GCA to a touch and go. On the downwind leg at airport #3 the student pilots were changed and a new student completed the landing checklist and commenced the next GCA. The aircraft made a normal landing. After about 900 feet of roll-out, the instructor and students heard the landing gear warning horn. The landing gear handle was checked-down by the instructor, but it was too late; the partially retracted port main mount allowed the port prop to strike the runway, causing severe engine/prop damage.

Takeoff attempts were aborted and after a wild slide, the aircraft halted and everyone exited without injury.

Grampaw Pettibone says:

Holy distraction! During the roll-out the instructor was critiquing the student's landing as the warning horn sounded. The instructor inadvertently raised the landing gear handle while still on the ground. Being an instructor pilot is tedious, rewarding and demanding work. It requires total attention and supervision every moment. The instructor in this accident permitted himself to be distracted. He raised the landing gear handle vice the flap handle. If I had a nickel for every accident caused by memory failure, I could buy a farm and retire. Remember – every landing is a separate evolution warranting special attention – especially when the other guy's flying. I don't trust nobody with my ole hide. Your hop's a flop when the thinkin' stops!

Sad Story

An A-4B departed a naval air station for what should have been a routine cross-country training flight. The flight had been requested, approved, briefed, planned and filed as an IFR cross-country training flight to a midwest NAS. The pilot was cleared IFR at 31,000 feet, but very shortly after takeoff he cancelled his IFR, reporting that he had a compass malfunction and would proceed VFR. Approximately one hour later he requested and received a change of flight plan to an Air Force base over 900 miles away and filed for an en route time of two hours with two and a half hours of fuel remaining.

There was no further communication between the pilot and control agencies for the next hour and 20 minutes. Then he requested the winds at 35,000 and 40,000 feet.

Approximately two and a half hours after refilling in the air, the pilot contacted the control tower at the destination field and informed them he was 15 miles out and requested landing instructions. He also reported fluctuating fuel pressure and requested the status of the Vortac serving the field. The tower advised him that the Vortac was down for maintenance and that a Notam stating it would be out of service was sent the day before. The pilot then requested a DF steer and the tower controller gave him a heading to the field.

Some 10 minutes after initial contact with the Air Force tower, the pilot reported a flameout and indicated he would not be able to make the field. The tower informed him that there were no auxiliary fields near his position and that the bailout/ejection area was 10 miles northeast. At this time the pilot informed the tower that he was passing through 9,000 feet. A short time later the aircraft crashed in the desert nine miles east of the Air Force base. The pilot ejected at an estimated altitude of a little more than 10 feet above the ground and was fatally injured.

Grampaw Pettibone says:

Great balls of fire, what waste! This well trained and experienced lad made some real bad moves on this flight and after they accumulated to the point of no return, he made the fatal mistake of staying with the aircraft until he was too low to eject safely.

Most of us have committed errors hard to explain, but this pilot's decisions from takeoff to flameout are beyond reason. Here's a pilot whose demonstrated ability and personal conduct were such that his cross-country request was approved without reservation; yet he cancels his instrument flight plan just after takeoff, proceeds VFR through APC, with insufficient fuel and no Notam info, changes his flight plan to a field hundreds of miles away and overflies good en route fuel stops trying to make his new destination.

Poor judgment and lack of professionalism were the primary factors in this accident. Several Navy and FAA directives were violated; but neither Natops nor any other publication ever was written to take the place of a pilot's judgment. (August 1964)