



GRAMPAW PETTIBONE

Harried Harrier

Four AV-8A *Harriers* were made ready and assigned to specific pilots who would fly them exclusively during a one-week training exercise at an expeditionary field. One of the aircraft was down for a leaky fuel control unit (FCU). After consultation with power plant personnel and maintenance control and technical representatives, the aircraft maintenance officer (AMO), who was also the detachment officer-in-charge (OIC), changed the discrepancy to an up gripe, and no corrective maintenance action was performed. The power plant quality assurance representatives disagreed with the AMO's decision and actions.

The following day the four *Harriers* deployed. At the expeditionary field, the leaky fuel control aircraft completed six sorties within three days before it was again grounded. The fuel control leak had become more severe. On this occasion the OIC, after consulting his maintenance crew, ordered the FCU changed. Because of a shortage of maintenance personnel, the work was performed by a power plant mechanic and a quality assurance representative during the evening and morning shifts. No collateral duty inspector (CDI) was available to check the work.

The OIC, the pilot assigned and maintenance control personnel mapped out a procedure to field test the newly-installed FCU. The plan required a low-power engine turn with FCU adjustments, followed by power acceleration checks, and final FCU adjustments at low power.

The well-intended plan was never executed. The assigned pilot departed the area with the OIC to file their flight plan for the anticipated return



flight to home base. A substitute pilot, who had not flown the aircraft and had not been briefed on the procedure, was tasked to perform the low-power turn and engine acceleration checks.

Due to flight line congestion, the initial low-power turn and FCU adjustments were not performed. A power plant representative equipped with a communication headset was stationed at the taxiway throat to assist the pilot with the acceleration checks. The substitute pilot, unaware of the agreed-upon procedure, taxied past the waiting mechanic, returned to the line and secured the engine. He described the engine acceleration performance to maintenance personnel who made subsequent adjustments to the FCU.

The aircraft was readied for the flight to home field. The power plant and maintenance control representa-

tives requested that the aircraft be flown by a qualified post-maintenance check pilot and proceed directly to home base, which was only 20 minutes away.

The Detachment OIC and the subject *Harrier* pilot returned from base operations, assumed their FCU repair plan had been carried out, and prepared to launch.

During start, the trouble engine rpm hung momentarily at 22 percent. The pilot nudged the throttle forward to ensure a smooth start and noted that idle power stabilized at a lower rpm than expected. Subsequent checks prior to takeoff showed the rpm to be barely within acceptable Natops limits. A power plant mechanic assisting with the launch asked the pilot if the idle rpm was O.K. The pilot nodded affirmatively and then taxied as aircraft number four for the flight to home base.

The division flight leader elected to return with all four aircraft around a circuitous one-hour route in order to exhaust fuel from the external tanks. Upon arrival at home base, the four *Harriers* entered the traffic pattern for an overhead break. At a five-second interval, the pilot of number four extended the speed brakes and slowly reduced power, keeping the throttle about one-half inch forward of idle stop. At 250 knots he lowered the landing gear, checked 1,500 feet of his altimeter and then observed a warning light. Surprisingly, he noted the engine rpm was at 15 percent. He immediately pushed the engine relight button and lowered the aircraft's nose altitude in order to obtain sufficient airspeed for engine relight. The engine did not respond. Passing through 1,000 feet, the pilot broadcast that his engine had flamed out and that he was ejecting. He exited the aircraft



at 400 feet in a 10 to 15-degree dive with a 5,000 foot-per-minute sink rate. The aircraft was destroyed; the pilot received serious injuries.



Grampaw Pettibone says,

Holy hopeless *Harrier* hazards! This crowd was just an accident looking for a place to happen – and found one!

To Gramps, this episode reflects one of the most colossal collection of screw-ups ever corralled in any one consortium. The decision to Up a Down aircraft without performing proper corrective action violates all sound maintenance practices. The fragmentary or total lack of supervision, and the failure to provide adequate personnel, adhere to prescribed maintenance procedures, consult technical publications or to inspect work, coupled with some downright dumb decisions, resulted in serious injury to the crewman along with the destruction of an expensive aircraft.

Problems like these have long been characteristic of potential disasters associated with small detachment operations, good intentions notwithstanding. And in this case, like most others, I'm sure there were many. There certainly appears to have been little else.

Nonprofit organizations don't need a tax shelter like this, but you can rest assured that the taxpayers need a shelter from such a nonprofit disorganization as this.

A Matter of Priorities

Rain fell in a steady drizzle as the

F-14 *Tomcat* rolled, under tow, from the flight line to the wash rack area where it would receive its regularly scheduled weekend scrub in preparation for the following week's flight schedule. The brake rider, concerned with the rain, closed the canopy to protect himself and the sophisticated cockpit instruments from the steadily increasing drizzle.

Once the aircraft was parked and chocked, the brake rider secured the cockpit and attempted to exit. He actuated the normal canopy select handle; however, the canopy moved only a couple of inches up off the cockpit sills and stopped. Realizing that the nitrogen charge must be low, he then attempted to manually push the canopy open but with little success. The canopy moved only another two to three inches and stopped.

The brake rider signaled to the tow crew supervisor that the canopy would not open. The tow crew checked the canopy actuator nitrogen gauge and noticed that the pressure was very low. The crewman turned to bring the nearby nitrogen cart alongside the aircraft to service the canopy actuator system. As he walked toward the cart, he was startled by a loud explosion, and realized immediately what had happened. He turned to see the double cockpit F-14 canopy fall to the deck near the aircraft. After the dust, smoke and debris had cleared, the brake rider exited the aircraft.



Grampaw Pettibone says:

Jumpin' Jehoshaphat, if this doesn't beat all! Within the previous

two months, this young lad had received two ejection seat/canopy checkouts, had recently completed brake rider school and was fully qualified.

During the tow from the hangar area, the brake rider noted the time. He became concerned about the lateness of the hour and the pending squadron basketball game in which he was to play. When the canopy failed to open, his concern mounted. Impatience led to frustration. He was not content to wait the 5-10 minutes which would be required to service the canopy actuator and open the canopy. Timely attendance at the squadron basketball game had now become his most pressing priority. Fully aware of his actions, the brake rider consciously selected the canopy



jettison handle, blew the canopy from the aircraft and climbed down from the cockpit.

Following the incident, the brake rider was escorted to the base dispensary. He was administered a physiological and psychological profile and determined to be fit in all aspects for duty.

This literally blows my mind! Maybe this young lad was, in fact, fit for duty. Well, I am fit to be tied! His irresponsible actions resulted in a quarter-of-a-million-dollar damage to the F-14 aircraft. We don't need, and can't afford, that kind of help, gents!