

Aerobits



LIGHTNING STRIKE—There's been a lot of talk about lightning during the past year or so. Here is another report: A C-130 transporting a crew and chopper to an aircraft crash site was struck on the radome. There was a subsequent explo-

sion in the left pylon which began to burn and continued until shortly before landing. After the aircraft was on the ground, inspection revealed a six-to-eight-inch hole in the radome, radar antenna damage, and the pylon damaged beyond repair.

HOW ARE YOUR SUNGLASSES?
Credit the airlines for pointing up a hazard that design-changes in sunglasses have produced.

A pilot is highly dependent upon his peripheral vision to acquaint him with the presence of others in air space. If the pilot wears corrective lenses in the form of spectacles or if he wears sunglasses, the frames of either of which block out his peripheral vision, he is depriving himself of nature's radar, his physiological early warning system.

Many of the styles of today's sunglasses have either taken on a certain wrap-around effect or employ the use of extra wide temple pieces that become, in effect, blinders . . . and THAT'S the hazard.

One airline already has added a paragraph to its Flight Manual, prohibiting pilots in flight wearing sunglasses or spectacles having wide, nontransparent or vision-restricting temple pieces.

Are you a stylish hazard, or a good "old fashioned" see-it-all?



FSF Safety Bulletin 64-206



THE SUPREME SACRIFICE—For the little mountain town on the cross-country highway it had been a normal winter day. Snow had been falling, and it continued on into the evening. Wind swirled the snow into a ground blizzard. The curve at the outskirts of town had become quite treacherous. The road was icy. Several local officials, familiar with the road, had skidded into the west-bound lane while rounding the curve—and they were driving at reduced speeds. Had there been traffic westbound, they knew they wouldn't have been able to avoid a collision.

Early that morning an airman had signed out PCS at an Air Force base 900 miles away and headed toward this curve. His intended destination was on east. To reach the curve on the edge of

the mountain town shortly before midnight he had averaged 53 miles per hour for 17 hours. He was alone. According to investigators he was traveling about 50 miles per hour coming into the curve. He didn't have a chance at such speed. He lost control, skidded into the west bound lane and collided head-on with a semi-trailer creeping along 18 to 20 miles per hour, due to road and weather conditions. The front wheels were knocked off the truck in the impact; it went off the road and turned over. The airman's car was demolished. Death was instantaneous.

(Ed. Note: PCS travel, TPA authorized, is predicated on 275 miles per day. This airman had crowded more than three days driving into 17 hours.)

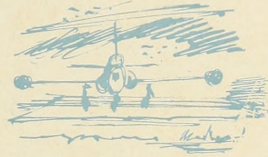
IT WENT THATAWAY—We will agree that an airfield at night can be very confusing, more so when it is a strange field. The following incident involved a T-33, with two pilots aboard.

On a predawn departure, the pilot taxied to the south end of runway 32. At the end of this runway there is a large paved area with four taxiways intersecting the runway. As the pilot approached takeoff position, he had the runway clearly in sight. Upon reaching the runway, he turned left and proceeded toward the approach end in order to use all available pavement. Entering the five-way intersection, he observed an object in the darkness which he thought to be the MA-1A webbing. What he observed was actually a row of flags which were in place to indicate that this taxiway was closed. The pilot maneuvered toward the flags, lost sight of the runway lights, and aligned himself with the unlighted taxi-

way, assuming this to be the runway. He was positioned at the end of runway 32 and in the darkness it was not possible for the tower operator to determine that he was not properly oriented. After rolling approximately 1000 feet, the pilot realized that he was not on a runway. He initiated an abort, but was unable to stop on the remaining pavement. The aircraft passed through a floodlight installation and barricade, crossed 50 feet of soft sod and stopped on a gravel road.

Fortunately, this turned out to be a lucky day for these pilots and the Air Force; there was only minor damage to the aircraft. It does not tax the imagination to picture the catastrophic results that could have been, due to the elimination of one simple cross-check—COMPASS HEADING VERSUS RUNWAY HEADING.

Major S. R. Smith
Directorate of Aerospace Safety



B-66 TAKEOFF HAZARD. Arresting gear can be very useful for stopping an aircraft, but when it's engaged while the aircraft is taking off—well, that's another story.

On takeoff the tail skid on a B-66 engaged a Navy abort arresting gear. Fortunately, the skid is not stressed for stopping purposes. It pulled loose, causing scratches and dents in the dragchute doors and chaff dispensing tail cone and a couple of small holes in the tail cone radome.

Takeoff was on a runway with a .59 per cent slope. The aircraft climbed but the runway climbed faster. The pilot and

crewmembers said the liftoff looked and felt normal. The tower officer stated that the entire takeoff appeared normal. The most probable cause of this mishap was that the aircraft settled or failed to climb after liftoff from a still-rising upslope runway.

Under the right circumstances, this hazard could apply to many aircraft, particularly those with steep lift-off attitudes. Pilots must be aware of all obstacles to takeoff, and performance of both the pilot and the aircraft must be equal to the situation.

Lt Col Eugene J. Budnik
Directorate of Aerospace Safety



BAGS AWAY! While cruising at 35,000 on a cross-country from Tyndall to England the armament rotary door on an F-101 inadvertently rotated to the primary side, then closed. In the process the crew's luggage—one B-4 bag and one plastic suit bag—were dropped. These "soft bombs" had been hung on the primary side of the door. Armament panel configuration at the time was: arms

switch, safe; arm selector, viz ident; ejector racks, locked. The pilot notified Atlanta Center of the incident and continued to destination for RON. Post flight investigation failed to reveal the cause of the malfunction. Door creep from a hydraulic defect hadn't occurred and radar personnel were unable to produce an inadvertent fire signal. Civil authorities have been asked to be on the lookout for two bags.

