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"The discipline which makes the soldiers of a free country reliable in battle..." This prelude is often quoted by Army types and is from Major General John M. Schofield's dissertation on discipline. It spells out some basics for the Army commander to heed if he is to be successful. But we, as Air Force crewmembers, have few quotations from way back when which can spell out success. The old "keep the light on the star and shut up" or "check in and go cold mike" may have had their place, but we lost a lot of pilots and aircraft under that approach.

Still, in the case of fighter aircraft, we find that one aircraft cannot always hack the job and, for the sake of mutual support, a certain amount of "put it there and keep it there" is necessary. Additionally, in multi-crew aircraft we must depend on others to do a job, do it right, and do it when required. What we're really talking about is flight discipline and it applies to each and every Air Force crewmember, whether he is flying the O-1, the C-130, the F-111, or the F-105. If we are to win, and that is the name of the game, then we must be able to count implicitly upon each man to do his assigned task.

Now we get to the guts of the problem. What is it that makes the "airmen" of a free country reliable?

First of all, we must have knowledge not only of the assigned task, but also the method to attain the goal. We may even want some answers to the "whys," which should increase our motivation to do the job right. We must also know our particular weapon system. What can it do? What can't it do? What does it do best? Answers to these questions usually come from the books and from experience. Now all we need is knowledge of our fellow crewmember's capability, which is best derived from application of good training and standardization programs.

But, we're not there yet. As nebulous as it is, flight discipline does not stop at just knowledge. A willingness to subvert oneself to the leadership of another or, if you are the leader, a willingness to accept the responsibility of command, is essential to flight discipline. A leader who doesn't want to lead and a follower who doesn't want to follow are both invitations to disaster.

Finally, and here is where we put it all together, how do we perform when out from under the gun? Can we do it "as briefed," "by the book," and "as directed?" If so, then we are well on the way to good flight discipline.
by Pat Henry
Experimental Test Pilot
McDonnell Aircraft Company, Edwards AFB, CA

Some recent conversations with F-4 drivers in the field have shown that considerable interest exists on the subject of stick force lightening. Regrettably, very little information is available about this phenomenon. My aim in this article is to discuss what it is, why it happens, and where to look for it. Hopefully, that will clear up some of the confusion and make it easier to avoid the pitfalls associated with maximum performance maneuvering in the region where stick force lightening can be expected.

Looking briefly (and very basically) at aerodynamics involved during maneuvering, it is common knowledge that as angle of attack (AOA) increases, the airflow over the wing will eventually begin to separate. The significant point in this case is that the separation occurs first along the wing trailing edges, primarily on the outer panels. Since the remaining effective wing surface must carry the load, the center of pressure (CP) shifts inboard and forward. Such a shift in the CP effectively produces a nose up pitching moment; an imbalance of forces in the nose up direction. This is really a very gradual and subtle change, but it means the stabilator appears to become more effective as we continue to increase the angle of attack.

Results? A given amount of stabilator travel at high AOA produces greater change in AOA and G-load than at the lower maneuvering levels. Going hand in glove with this is longitudinal stick force. As the stabilator becomes more effective, it stands to reason that stick force per G decreases, and we have the infamous “stick force lightening.”

If you will, shift your rapt attention to the graph which has been purloined directly from the Category II Stability and Control Evaluation of F-4E aircraft. It was purposely chosen to illustrate the point because it’s an extreme case. In particular, note the region of 4.5 Gs.
5.5 Gs. The stick force gradient goes to zero right around 5 Gs for this particular set of flying conditions. From 5 Gs on, no additional stick force would be required to pull higher Gs; in fact, you’d best be ready to release some back pressure if you pull much beyond that plateau.

A very important point needs emphasis here. Even though the stick force gradient goes to zero or beyond, the pilot is still pulling in the positive direction, such as, back stick for positive Gs. Twenty pounds worth, in fact. He need but reduce back pressure to reduce G-load.

If you're like me, you're not inclined to fly like the Thunderbird drivers with lots of nose down trim. True, it build up the muscle in your drinking arm, but most ple find it pretty tiring. Naturally, we trim out most of stick forces. Beware; there's dangerous footing here. Imagine the most extreme case where all twenty pounds of stick force were trimmed out. Your only clues as to how close you are to overstressing the bird are the accelerometer (difficult to scan while maneuvering in section, checking your six, etc.), and the tightness of your G-suit. A little back stick pressure would help. More important, with little or no stick pressure resisting you, an unexpected gust, jet wake, or heavy hand on the stick will almost guarantee a G-overshoot. Small stablilator changes in this region produce exciting results, so why not leave everything possible working for you? Trim with care!

Finally, a word about where stick force lightening is most prevalent. Don't pin me down too close, please, but you should be on max alert for it in the mid-altitudes (15K ± 5K) and from .85 to .95 mach. AILspeed/altitude combinations in that ballpark will usually give more than enough lift and stablilator power to pull into G-loads that could overstress the aircraft, before you get to such limiting factors as wing stall, buffet boundary, and the like. It's really not as bad as I may have made it sound, but remember, when you're maneuvering in the stick force lightening region, you're operating pretty close to the edges of the envelope — do so judiciously.
ERR0R AND EXPEDIENCY

Recently, in another command, a crew chief was severely burned as the result of an initial error and an expedient attempt to correct the effects of the error. Here's what happened:

Shortly after engine start in the F-104, the crew chief and his assistant noticed fuel dripping from the bottom of the aircraft just forward of the engine intakes. Unknown to the air crew, the crew chief scrambled up on the right wing and then onto the fuselage. He removed the forward fuselage fuel cap and inserted a screwdriver into the well. Suddenly fuel sprayed out of the filler valve, doused the crew chief and was drawn into the engine intake where it ignited. The crew chief was engulfed in flames and fell head first onto the ramp. Flight line supervisors observed the fire and ran to the crew chief's aid. They removed him from the inferno and smothered his burning clothes. The pilot shut down the aircraft and both occupants quickly exited. The aircraft suffered very minor damage but the crew chief had first, second, and third degree burns over fifty percent of his body. In all likelihood he will be in the hospital for more than a year. Of course the story isn't complete so let's backtrack for a moment.

Seeing the fuel leak, the crew chief seemed to know what was causing it. He assumed (correctly) that the retention chain which connects the outside fuel cap to the filler neck was jamming the fuel tank flapper valve which prevented complete closure of the valve and allowed the fuel to escape through the dump mast. This couldn't happen if the chain were of the proper length and connected at both ends, but this chain was not the proper length and it was broken on the filler neck side; the other end was still attached to the fuel tank cap. When the cap was put into position, the chain dangled below and into the flapper valve, unseating the valve slightly. With the engine running, the crew chief tried to free the valve by opening the fuel cap and pulling on the chain, but that didn't work. So he inserted a screwdriver into the well and pushed on the valve so that he could free the chain. Fuel, under pressure, spewed out. The rest you know.

The first error was in not replacing the retention chain which he knew was broken.

Then, probably because of expedience, he didn't have the pilot shut the engine down to correct a problem which apparently had precedent.

The results were grim.

IT'S NEVER THE FIRST MISTAKE

Safety pins played an important role in a recent A-37 incident. A life support specialist had received a work order to remove the seat survival kits from several aircraft. He removed most without incident, but then as approached the next airplane, he entered a sequence of events which almost led to disaster, a sequence which started sometime after the airplane's last flight.

Following the after landing and engine shutdown checklists, the pilot began the sequence by installing the canopy jettison T-handle safety pin incorrectly. Then the potential for disaster abruptly ended when the crew chief, following his post flight checklist, installed the canopy remover safety pin CORRECTLY. With this pin correctly installed, the canopy won't jettison . . . period. Now back to our life support specialist — remember where we left him? He was approaching the plane. Looking for a way to get the canopy up, he opened a small access door and PULLED THE EXTERNAL CANOPY JETTISON HANDLE, (OH NO!) Nothing happened! That last pin, installed by the crew chief, was the saver!

Several things come to mind at this point. Thought number one — people shouldn't pull handles on airplanes if they aren't 100 percent sure what that handle does. Thought number two — people who install pins on airplanes should make sure they do it correctly (In this case one did and one didn't). Thought number three — it's nice to know that we DO have effective safety systems that work — even when a portion is made ineffective through improper use.
with a maintenance slant.

REMEMBER GLENN FORD?

A recent incident in a C-130 calls to mind an old Glenn Ford movie where Glenn diligently pursues the cause of a fatal airline crash to find that an errant cup of coffee had shorted some electrical gadgets in the throttle pedestal, which subsequently caused the crash.

In our story, the C-130 pilot was turning onto the base leg of the traffic pattern when it became obvious that the airplane wanted to turn more than he wanted it to. He glanced at the trim indicators, noting that the aileron trim was full tilt. He then pushed on the aileron trim switch a couple of times but it didn't work. Completing the landing without further incident, the jock turned the key over to maintenance. By this time it's no secret, they found, Coffee!!! At some time in the past, the coffee had been spilled (probably by a pilot) and had entered the trim switch electrical goodies via the holes (deteriorated) in the rubber boot at the base of the trim switch.

The pilot who spilled the coffee should have written it up, no doubt. But it's also a good idea for the crew chief to investigate when he spots the tell-tale coffee stains.

Remember Glenn Ford!

PIN CHECK

A life support specialist in another command recently performed the ten-day inspection of the F-4 aircraft parachutes. He found that the back seat parachute safety pin lanyard was not routed through the alignment ring. He investigated further and found that the safety pin was installed backwards and was not safied. THE PARACHUTE WOULD NOT HAVE OPENED HAD IT BEEN USED.

A check of the lanyard routed through the alignment ring is part of the crewmember's checklist. Not once in fifty day's worth of operation was this checklist item caught. In addition, the ten-day parachute inspection calls for both the lanyard routing and safety pin to be checked. Five previous ten-day inspections failed to catch the mistakes. All we can do is nod our heads in silent salute to the troop who did his job correctly and found the mistake. To the rest of the people, crewmembers and inspectors alike... Well...

GET YOUR TEETH INTO IT

While arming an F-4, one of the load crewmembers, complete with checklist in one hand and screwdriver in the other, ran out of places to put things. He removed the nose gun safety pin and held it in his mouth. After buttoning up the gun door he started to transfer the pin from his mouth to his hand when the pin was gulped down by the F-4. Instant indigestion!

This unit is now using pin bags and two men, one to hold the checklist and one to do the work.
Somebody once said, "Even old ideas can be good ideas." In keeping with that philosophy, TAC ATTACK is pleased to present a collection of stories published in 1942 by the Army Air Forces under the direction of General "Hap" Arnold. The series is entitled "Lessons That Live" and all totaled there are seventeen stories, all of which will be presented, running consecutive issues of TAC ATTACK.

The series is introduced by General Arnold and although the authors are anonymous, the narrative accounts of their experiences, told in their own words, are without doubt...

A MESSAGE FROM GENERAL ARNOLD

A short time ago I asked all pilots to submit, in narrative form, accounts of their narrowest escapes from fatal accidents. The response was instantaneous and tremendously gratifying.

These narratives have already become dog-eared from intensive study by statisticians, engineers and other specialists in the field of accident prevention. The yield from these studies is a rich harvest of information which will help to make our Air Forces, already the safest in the world, even safer in the future.

I promised to publish some of these narratives and this booklet is the fulfillment of that promise. Of the hundreds of accounts received, all well worth printing, these few have been selected, not because they are the best, but because they are the most typical.

In reading these stories, note well, as I have, that accidents or near-accidents are almost invariably caused by pilot failure rather than machine failure, the weather, or any other factor. This being so, it follows logically that accidents can almost invariably be prevented by better, surer flying. Accidents don't happen; they are caused. Knowing the causes, it should be easy to prevent them.

H. H. ARNOLD
Lieutenant General, U. S. Army,
Commanding General, Army Air Forces.

No. 3 of 17
Courtesy of Lt Col H. M. Butler, 4500 ABW/SE
DECEMBER 1972
Mud baths, they say, are healthful. But I don't recommend the kind I took that chilly October morning. I was flying a new P-40E on a simulated dive-bombing mission and everything had gone along beautifully. As we neared home I was somewhat disturbed to note that the flight leader was landing downwind; however, I quickly tossed my misgivings aside, and I followed him in to land.

While I was on my approach the wind changed to a three-quarter tail wind from the left and Old Sol was shining straight down the runway. The glare from the sun on the wet runway caused me to misjudge my landing. My ship hit the runway and bounced. This caused the left wing to drop and the plane veered off to the right due to the wind from the left rear quarter. I applied the left rudder and brought the right wheel back down on the runway, but unfortunately I had over-corrected and the ship immediately started off to the left.

As luck would have it, the left side of the runway was covered with a thin coating of mud that was as slick as grease. Brakes and rudder failed to straighten out the plane and it went off the runway, where the wheels bogged down in the mud. The ship did a slow and awkward dive into the ooze, then balanced momentarily on its nose while I hung ludicrously out of the cockpit.

I realized that the plane would go on its back as soon as it finished its little balancing act, so I frantically clutched the sides of the seat and ducked my head. It came over with a crash and my head was dunked up to my Adam's apple in mud. Fortunately, the ship did not have enough forward momentum to slide on its back; if it had, my body and my noggin would have parted company right there. As soon as I could get oriented — probably a second or so although it seemed a year — I cut all the switches and began digging out.

I came through that experience without a scratch. Lucky, considering all the mistakes I made. I shouldn't have tried to land downwind and I shouldn't have looked into the glare. Obviously, I should have given it the gun and gone around when at first the plane struck the runway crooked. I hope others will profit by my mistakes. I know I have!
by Captain "Buck" Sheward
16 TATS, Little Rock AFB, Arkansas

We’re all pretty good. When it comes to flying airplanes, there is no better group on earth. We’re the best and we know it. We all have a great amount of self-confidence and we need it to hack the mission. But there is an inherent danger in this supreme self-confidence, this self-possessed knowledge about our skill as airmen. Unless you are aware of this danger and successfully avoid it, it can kill you. I realize that this is a pretty drastic comment, but I can prove it with examples from personal experience, and the thoughts of one of the Air Force’s greatest leaders. Let me explain.

During most of ’68 and early ’69, I was assigned to the 23rd TASS, Nakhon Phanom RTAB, Thailand, as an O-2 FAC. Like anyone else on a combat tour, I formed many deep friendships – the kind of relationships people form during a prolonged period of common stress. I want to tell you about two of the friendships which ended in needless tragedy.

One of my good friends was Will. Will was a great FAC. He was very probably one of the best FACs in SEA. Because of this, he flew many of the dangerous and very critical missions. He was an instructor and he did everything by the book – almost. That “almost” proved to be his failing.

There was a directive at that time that no FAC in our sector of operations would fly below a certain absolute altitude. I’ve forgotten exactly what that altitude was,
it was well below the effective range of the guns in our
No FAC in his right mind would go that low
away. But we were hacked off. After all, we were the
"best." We didn’t need anyone telling us how low we
would go. Where did those guys at headquarters get the
nerve to tell us, “the best,” how to do our jobs? We were
upset but we complied. Well, most of us complied, Will
didn’t.
Will flew very low, not in the hot areas where it would
be suicidal, but in areas where things were cool. He got
away with it for a few months but one day it happened.
Will crashed — flew into a mountain. The weather was
VFR and there were no enemy defenses in the immediate
area. He simply had gone too low, could not recover, and
crashed. The 0-2 was not the hottest aircraft the Air Force
ever bought. Maybe the “guys at headquarters” realized
this.
Will was one of the best, but he and the observer who
was with him that day were dead, claimed by
over-confidence and that unnamed mountain in SEA. It
was a personal tragedy for me, but it wasn’t the last I’d
experience for the same basic reason.
Rich was older than Will, more experienced and more
stable. He was a command pilot and had been an IP for
years before he became one again at NKP. Rich did
everything by the book — almost. Again, that “almost”
vied fatal.
there was a directive in PACAF at that time, that all
aircraft recoveries were to be made from an instrument
approach if possible, PAR if available. No one knows why
Rich chose a VFR pattern that particular night. He had
escorted a damaged A-1 to the “fence.” It had been a long
mission for Rich and his student, but not long enough to
cause fuel problems. I’m sure Rich was tired. Under these
conditions a PAR would have been the safest thing. Rich
chose the VFR pattern.
On downwind approaching base, he went into the
trees, power on, wings level, slightly nose low. The engines
were operating normally. The accident board could find
nothing mechanically wrong with the airplane. Rich was
one of the best, but he was dead and he took another
pilot with him.
Years ago General LeMay initiated a program in SAC
whereby the wing commander of any wing which
experienced a major aircraft accident would personally
brief him on the accident. During one such briefing, he
cut a wing commander short with words to the effect:
“I don’t want to hear this nonsense about this pilot
being the best in your wing. Don’t tell me that you
can’t understand because there were none better. I’ve
heard this story a dozen times and I’m tired of it. If
that pilot were truly the best, he would still be alive.
‘He’s dead.’

FAC ATTACK

It’s a known truth that the hot pilots, the ones who are
so good that they can throw away the book and do things
on their own, get into serious trouble sooner or later. On
the other hand, the pilots who realize that they are not
perfect, the ones who rely on directives for guidance,
seem to live to enjoy a ripe old age. The difference is
more than incidental.
The facts are clear. The common denominator in
the current rash of fatal accidents in TAC is a failure to follow
directives. The Air Force recognizes this trend, TAC
recognizes it, and those of us at the lower levels can
recognize it if we look at our own background. When you
become so good that you can throw away the book, it’s
only a matter of time . . . you’re headed for serious
trouble.

ABOUT THE AUTHOR

Captain C. W. “Buck” Sheward is a '64 grad of the Air
Force Academy. After pilot training, he spent three years
in C-130s, followed by a combat tour in O-2s, then back
to C-130s. He is presently an instructor pilot in the Phase I
C-130 school at Little Rock AFB.
His article was originally a talk he prepared for a
squadron flying safety meeting. Buck is also the squadron
chief of safety.
Minimums

Two incidents which occurred a week apart in different aircraft and different parts of the world bear uncomfortable similarities.

In the first incident, nine RF-101Cs in elements of three were launched IFR for a fly-by at the departure base. With the existing visibility at two miles in ground fog and haze, the intent was to hold above the weather until it cleared to at least five miles and then press in for the nine ship fly-by.

Shortly after departing the holding fix for the fly-by, the leader of the third element lost sight of the second element and continued to descend, entering a solid undercast. Suddenly he realized he was too low and called for his flight to pull up. The element later rejoined the formation in the clear and completed the mission.

During post flight, maintenance found obvious evidence that the right wingman of that third element had struck a tree!! It doesn't take much imagination to see what a delay of one more second would have done to the right wingman.

The findings, as you've probably surmised, list supervisory error (element leader) as primary and supervisory error also as contributing in that the fly-by was launched in weather below the criteria established in AFR 60-6. The reg states “Minimum weather criteria for participation in aerial reviews and weapons demonstrations, including those performed in conjunction with good will flights, will be at least 2500 feet ceiling and visibility of at least 5 miles.”

In the second incident, an F-111 was shooting a GCA after returning from a combat mission. The pilot states that at 15 miles on final he had the runway in sight but at three miles out he observed a patch of fog covering the approach end. He entered the fog at one and one-half miles and lost sight of the runway. At one mile from touchdown, GCA transmitted that he was going well below the glide path and to execute the missed approach if field not in sight. Seeing 200 feet on the radar altimeter the pilot initiated the missed approach and came back around for another, and this time successful, approach.

It was not until post flight that the facts came to light. During the approach, the airplane had hit a tree to the tune of about $17,000 worth of airplane damage. What happened? In transitioning back and forth between instrument and contract flight, the pilot let the F-111 descend far enough below minimums to strike a tree.

Again, a split-second more . . .

Gentlemen, there are countless cliches which could be listed here, but you know them all. You know the reasons, you know why they were established, and you know how to operate within them. Give it some thought.

Attention Safety Officers!

Did you know that the vast accident and incident data computer housed at the Air Force Inspection and Safety Center (Norton AFB) is practically at your fingertips? Recently AFISC instituted a new and improved service of providing flight safety data to MAJCOMs. This service enables the major air command to telephone requests for computer bank data on a 24-hour, seven-days-a-week basis.

How does this help you? Got a study going? Need some data? You can call us directly (Autovon 432-7031 or 7032) and we'll bug (question) the computer. In a reasonably short time you'll have your material.

Simple, huh?
It Takes All Kinds!

Incident Reports are used for many reasons by many people. They are carefully analyzed for trends, potential problem areas, etc. Occasionally, they provide unexpected benefits.

Incident Reports can trigger responses that range from tears of frustration (Dammit - we just covered that last month!) to mild chuckles (They can't be serious!), to full fledged laughter (Hey, read this one - it's a beaut!).

Here are two recent examples that fell somewhere between the gasps and the guffaws.

In the first case, the - rt simply stated, "On takeoff gear would not retract. Attempts to retract gear were unsuccessful." The punch line that springs to mind on this one is, "Poor guy, he had to land gear down!" The second example is somewhat longer, but here's a condensed version. It seems that a trusty Thud was up on a night refueling mission, and was blessed with a shaky boomer. Fifteen minutes, numerous scratches, dents, clanks, flashes, thumps, and thuds later, a successful hookup was accomplished. Less than a minute later they disconnected, then started all over again. The flying gas station washed the windscreen this time, and the trusty Thud compressor stalled while IFR in JP-4. The report then states that, "The flight discontinued any attempt at air refueling." (Sounds reasonable!) The real punch line in this report came in the corrective action. The report rather tersely states, "It is contemplated that the senior air advisor will visit the air refueling squadron and brief them on the proper technique of air refueling F-105s."

Kudos

Hats off to the 12th Tactical Reconnaissance Squadron, Bergstrom AFB, Texas. They were recently named the recipient of the McDonnell Douglas trophy for flying 50,000 accident free hours in the RF-4C.

This award marks the first time any unit in the Air Force has been presented the McDonnell Douglas trophy for flying safety in the F-4 or RF-4 aircraft. The award is given by the McDonnell Douglas Corporation, the manufacturer of the Phantom II and Photo-Phantom.

The 12th Squadron was also the first unit to win awards for flying 30,000 and 40,000 accident free hours. The first 40,000 hours were flown in Southeast Asia in combat. The squadron was stationed at Tan Son Nhut Air Base, RVN, from September 1966 until August 20, 1971, when the squadron returned to Bergstrom.

Ed. Note: This feat was accomplished despite the fact that the assistant editor was assigned to the 12th in the distant past.
BOLT LOGS 625 ACCIDENT FREE HOURS!

In a recent non-accident of an F-100, the engine was removed for routine maintenance. While removing the engine, the technicians noted the front accessory case leaking excessively. During the subsequent removal of the accessory case, they heard a jingling noise inside the case. Further checking revealed that a bolt was lying free inside the case and that it had been there for some time! The accessory section was last opened during overhaul in October 1968. The engine had logged 625 hours since that date.

The bolt discovered in the accessory section (see photo) is the same one used to secure the accessory case to the engine. Since the case had not been opened since engine overhaul, it was assumed that the bolt had been there since that time. It doesn’t take much imagination to determine what would have happened if the right combination of negative Gs had been sustained any time during the 625 hours since overhaul.

This is a classic example of the problems which beset an accident investigation team in trying to determine the exact cause of an accident. It would be somewhat difficult to determine a primary cause, depending upon what remained of the crashed aircraft. Fortunately, this aircraft was not subjected to a great deal of uncoordinated negative G maneuvering, for had it been, it is felt that aircraft would, in all probability, have been an unexplained accident. Happily, we can record this as a non-accident.

Maj Bob Lawler
Flameouts which are the result of misrigged throttles still occur in the F-4 fleet. There have been a couple of mods to the throttle quadrant and improved rigging procedures have been established, but engine flameout incidents due to rigging still occur. Our fearless leader, an “ex” F-4 driver himself, remembered a procedure advocated by McAir some years back that apparently was once recommended but has since fallen into disuse.

Review of PRODUCT SUPPORT DIGESTS and discussions with various McDonnell Douglas people revealed the following recommended technique from an article by Pete Garrison which appeared in the 1st Quarter, 1968 edition of the DIGEST. McAir says the words and facts are still valid so without further ado, we plagiarize and provide the following useful information, courtesy the contractor.

Although the existing on-runway check of chopping the throttle from full to idle and checking to insure the fuel flow does not drop below 425 pph (without cool cam) or 225 pph (with cool cam), provides a valid check of throttle rigging, an additional check can be readily and easily applied during start.

As you bring the throttle to idle or above at 10 percent during engine start, the fuel flow jumps immediately to the minimum fuel flow dictated by the starting fuel cam (300 pph or 500 pph). As you follow the Dash One procedures, you move the throttle halfway up the quadrant and then back to idle. The getting back to idle is the key to Pete Garrison’s recommended procedure — snap it back and watch the fuel flow. If the rigging is marginal, the fuel flow will immediately drop to well below the minimum starting fuel flow (225 pph or 425 pph). You can snap the throttle forward and aft several times to confirm your findings. If the throttle is properly rigged, no amount of throttle chops will affect fuel flow during start. Until the engine reaches idle RPM, throttle position has no effect on the fuel flow — if properly rigged. If you are able to force the fuel flow more than 75 pph below proper starting flow when the throttle is snapped to idle, the rigging is out of limits.

The Dash One procedures for the throttle check on the runway still apply: It’s OK to fly it, but don’t snap the throttle to idle in flight. You may end up without power! Determining the fact that you have improper rigging while still in the chocks will provide you the opportunity for an early decision (whether to take the machine or get a new one).

In any case, remember — if you find marginal rigging — write it up!

Maj Burt Miller
on a wing and a STRAP

Operation Jingle Bells, that's what they called it. It was fourteen years ago this month that a brace of stateside C-130s was deployed to the Far East to bring back many of the fighter types and their support people who had been bugged out earlier in the year on a contingency gaggle. The whole deal was to get the troops back home in time for Christmas; Operation Jingle Bells was a good name for it.

The Herkys were new then, relatively speaking, and didn't have some of the refinements we have today. Like the trim. The birds of today have mechanical stops in the elevator trim system which limit the tab movement to...
degrees nose up and eight degrees nose down. Back then the limits were set at 25 degrees nose down and 27 degrees nose up.

But back to Operation Jingle Bells. Crews were returning from points West to various locations in the states dropping off people and equipment in time for the Christmas festivities. One crew was steaming in towards Walnut Ridge, Arkansas, bound for Langley Air Patch with a load of 23 passengers and nine thousand pounds of assorted cargo. Passing Walnut Ridge the crew was advised that all the weather in the world had descended upon Langley and that the command post had recommended an RON at Little Rock AFB. Clearance was received and the raft commander turned the Herky South for Little Rock then gave it to the copilot. While the AC was perusing the letdown chart, the C-130 suddenly nosed down. The copilot pulled on the yoke while clicking in shots of nose up trim. No good; the normal trim system didn’t work. Following emergency procedures, the copilot switched to the emergency trim system which worked as advertised, and enabled him to bring the airplane under control and back to straight and level flight.

With the immediate problem solved, the crew discussed the situation, kicking around the severity of the emergency and the options available. Since the emergency trim system was working OK, the pilot decided to continue to Little Rock, now less than 100 miles down the road.

Over Little Rock, the pilot eased the 130 into high
on a wing and a strap

station at 20,000, pulled the power to flight idle, dropped the nose, and applied a couple of jabs of nose down trim with the pedestal mounted switch. The airspeed began to build heading for the penetration speed of 250 knots. At 240 knots, the pilot eased back on the yoke to stabilize the speed at 250, but the yoke didn’t ease; it wouldn’t budge! He gave the yoke more grunt and worked the pedestal mounted trim switch. Nothing. The trim tab had runway to full nose down and no amount of moving the switch would make it respond! The pilot called for help from the copilot and both of them fought the now screaming Herky. Both pilots put their feet on the foot rests at the base of the instrument panels and pulled like hell, operating on the fringes of a pair of hernias. This effect broke the dive somewhat but not completely. The C-130 was still racing earthbound out of control. The pilot then yelled over the interphone for the loadmaster to bring a cargo tie-down strap to the flight deck.

The loadmaster dug around in the cargo compartment amid twenty-three wide-eyed passengers and came up with a strap, then struggled to the flight deck. The pilot told the flight engineer to tie the strap to the copilot’s control. The flight engineer to tie the strap to the copilot’s control. The pilot then yelled over the interphone for the loadmaster to bring a cargo tie-down strap to the flight deck.

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Column. This done, the engineer and loadmaster grabbed a strap, then struggled to the flight deck. The pilot told the loadmaster to shift the passengers as far aft as possible and to move some cargo to the rear of the aircraft. The loadmaster then returned to the flight deck to resume his additional duty as strap copilot.

Moving cargo and people aft had shifted the center of gravity rearward and now it was possible for the four of them to break the 300-500 fpm descent and level the aircraft. As the airspeed decreased, the pilot found that with all four crewmembers pulling on the yoke, more than sufficient muscle power was available to overcome the aerodynamic forces imposed by the insane trim tab. The altitude was now 5000 feet.

Meanwhile the pilot had declared an emergency with the controlling agency, and had received a clearance to just about anything. The aircraft was under control, such as it was, and the immediate problem was solved; but what now? There certainly weren’t enough parachutes to get everyone out and the old “you got it, I’m going for help” routine didn’t fool anyone.

Again the crew discussed the situation. It was obvious that a landing of a new breed would have to be attempted. At the slower airspeed less bicep power was required to move the elevator so the pilot instructed the loadmaster to move the passengers back to their seats. He then lowered the gear and experimented with flap positions, finding that with 50 percent flaps and all four of the crewmembers pulling on the yoke, the airplane could be controlled. But merely controlling the machine at 5000 feet was one thing; landing it was indeed another matter.

Fuel was no problem so the pilot decided to practice some approaches at altitude. The pilot made several simulated landings by calling for coordinated control inputs from the crew. Through this means the crew was able to develop synchronized movements, and the pilot was satisfied that he had a good chance of getting it on the ground intact.

The pilot set up for a long straight-in approach to Little Rock AFB, and started down the slope. Initially the glide slope looked like a roller coaster as the pilot called for elevator inputs while flying the ailerons, rudder, and power. A couple of miles before touchdown the crew’s movements became synchronized and the glide slope smoothed out. The airplane passed over the overrun and the pilot called for more back elevator and gradually reduced power. With the pilot and copilot hanging onto the yoke and the flight engineer and loadmaster pulling on the tie-down strap, the big Herky touched down in an attitude that ground observers called “normal.”

Sounds of jubilation erupted from the cargo compartment as the twenty-three passengers clapped, cheered, and stomped the floor . . . glad to be alive.

The crew had done an outstanding . . . no, incredible, job of getting the airplane on the ground safely. The tie-down strap technique never quite made it into Section III of the Dash One, but the elevator trim limits were changed.

Runaway trim can still be a problem in the C-130 but not of the severity that faced the crew on that winter day in 1968. In the finest tradition of TAC airlift, the crew dipped into the well of ingenuity and came up with a procedure that brought Operation Jingle Bells to a successful conclusion.

And, y’know, Christmas took on a special meaning that year.
Captain Gary R. Armentrout, 549 Tactical Air Support Training Squadron, 1 Special Operations Wing, Hurlburt Field, Florida, has been selected as the Tactical Air Command Aircrewman of Distinction for October 1972.

Captain Armentrout was flying as the instructor pilot for a student training night navigation mission in an OV-10A. When the gear was lowered, an unsafe gear indication was observed. Captain Armentrout executed a go-around and recycled the gear in an attempt to obtain a safe gear indication. Emergency extension and positive and negative G maneuvers also failed to lower the gear. Captain Armentrout then elected to land gear up. When attempted to raise the gear, the left main gear would not retract. Captain Armentrout was able to free the stuck gear for retraction by using a hard left roll with negative Gs. After several practice approaches Captain Armentrout flew his aircraft onto the foamed runway, shutting down both engines prior to touchdown to save the props. Investigation revealed the overcenter bungee had failed and was jammed in the gear linkage. Captain Armentrout's professional evaluation of and reaction to a critical inflight emergency undoubtedly averted a major aircraft accident and possible injury or loss of life. His near perfect gear up landing at night, from the rear cockpit, readily qualifies him as a Tactical Air Command Aircrewman of Distinction.
The long scarf syndrome refers to the entanglement of the scarf's free floating end into moving machinery. The death rate in 11 cases was an astonishingly high 45%. Prevention is simple and consists merely of removing or covering the scarf when worn near moving machinery.

The long scarf syndrome was described in a letter after we had cared for our first patient with this injury. Since then, we have collected reports of 11 cases that meet our criteria, i.e., the wearing of a long scarf, entanglement of its free end into moving machinery, and a resulting injury ranging from minor to fatal.

CLINICAL MATERIAL – Of the 11 patients presented in the Table, nine were females between the ages of 10 and 30. As expected, all accidents occurred in the winter.

Four cases are reviewed in detail to demonstrate various mechanisms of injury.

CASE 1. – An 11-year-old boy from Lexington, Mass., suffered total airway obstruction and respiratory arrest after his scarf became entangled in the engine of his snowmobile. The scarf was loosened and his mother revived him by mouth-to-mouth resuscitation. The boy recovered and was seen by his ophthalmologist for retrobulbar hemorrhages with retinal damage. Spontaneous recovery without visual damage occurred.

CASE 2. – A young mother in her early 20s from Rochester, Minn., was hauled out of her seat while riding a ski lift when her scarf became wrapped around an oncoming chair. She died of strangulation as she was carried down the chair lift, suspended by the scarf.

CASE 3. – A teenager in San Diego, Calif., sustained severe facial lacerations and bruises when her scarf became entangled in the rotating wheel of her boyfriend's stationary motorcycle as she leaned over to inspect it.
COLLECTIVE CASES REPORTED WITH LONG SCARF SYNDROME

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All these injuries and deaths could have been prevented by simple common sense measures. Ten of the accidents occurred in connection with winter sports, so the removal of long scarves should be included in the safety instructions at ski slopes.

CASE 4.– A 10-year-old girl from Fort Wainwright, Alaska, was knocked to the ground and dragged under a gate that failed to operate when her scarf became entangled in the rope tow at a ski slope. She passed through the gate and was dragged by her scarf into the moving machinery. She suffered only facial lacerations and bruises requiring surgical treatment.

COMMENT

The most striking feature of these accidents has been the very high 45% death rate. Accidents occur when the scarf's free-floating end becomes entangled in any moving machinery. The alertness of the involved person and the operating speed of the machinery correlate with the extent of the injury produced.

The new vogues, fads, and fashions frequently produce unsuspected inherent dangers. Wearing a long scarf exposes the person to such dangers. Life insurance companies warn of hazards from loose scarves. The long flowing scarf recalls the strangulation death of Isadora Duncan when her long scarf caught in the wheel of her boyfriend’s speedy car.

All these injuries and deaths could have been prevented by simple common sense measures. Ten of the accidents occurred in connection with winter sports, so the removal of long scarves should be included in the safety instructions at ski slopes.

TAC ATTACK

PERSONNEL AND EXPLOSIVES LIMITS

by Capt Robert W. Carmichael, Jr.
Chief, Explosives Safety Branch,
Hq TAC

By now everyone involved with explosives safety, either directly or indirectly, should have heard the old saw about exposing the minimum number of people to the minimum amount of explosives for the minimum amount of time. Strict time limits are not always possible; however, explosives and personnel limits are. The Explosives Safety Manual (AFM 127-100) has some very clear and specific guidelines for establishing personnel and explosives limits. To make sure that prudent and workable limits are provided, let us look at a few of the guidelines used in setting up these limits.

Personnel limits are required to insure that only personnel essential to the operation are in the vicinity of explosives. Essential personnel are workers necessary to complete the task safely, and may include supervisors, inspectors, and safety observers. The limits should be based on the type of explosives involved, type of operation being performed and the size of the work area. Personnel limits are not required and need not be posted for explosives locations involving only Class 1 explosives.

At first glance the "buddy system" may seem to contradict the minimum personnel rule, but a closer look reveals that there is actually no contradiction. The buddy system insures that personnel are ready to effect timely fire warning and rescue operations when necessary. This justifies the presence of two people when only one may be required to do the job.

Explosives storage facilities are designed and sited to store the maximum quantity of explosives. Accordingly, the explosives limits should be the maximum allowed by the available quantity distance and structure design. However, this same rationale does not apply to explosives operating facilities or other buildings not specifically designed and sited for explosives storage. In this case, the minimum amount of explosives necessary to insure a smooth, efficient, and safe operation should be established as the maximum explosives limit. This is true whether the operation is an egress shop with only limited requirements for Class 1 or 2 explosives or a preload facility requiring 50,000 pounds Class 7 NEW (Net Explosives Weight).

When essential to the mission, commanders may license locations for Classes 1, 2, and 3 explosives without regard to quantity-distance requirements. Class 2 explosives may not exceed 100 pounds NEW under this criteria and Class 3 may not exceed 50 pounds NEW. Note that these are maximum allowable limits and that smaller limits must be provided when possible. A specific limit must be established for each operation and location.

To be effective, explosives and personnel limits must be posted in the work area and included in any local publications prepared for explosives operations. To insure compliance, explosives limits should indicate the number of units or trays, etc., explosives as well as total.

Commanders, safety personnel, and supervisors at all levels must make sure that personnel and explosives limits are adequate to meet requirements, are properly posted, and are strictly observed.
TACTICAL AIR COMMAND

Maintenance Man Safety Award

Airman First Class Adrian L. Moen, 313 Field Maintenance Squadron, Forbes Air Force Base, Kansas, has been selected to receive the TAC Maintenance Man Safety Award for October 1972. Airman Moen will receive a letter of appreciation from the Commander of Tactical Air Command and a Certificate.

TACTICAL AIR COMMAND

Crew Chief Safety Award

Staff Sergeant George B. Patterson, 316 Organizational Maintenance Squadron, Langley Air Force Base, Virginia, has been selected to receive the TAC Crew Chief Safety Award for October 1972. Sergeant Patterson will receive a letter of appreciation from the Commander of Tactical Air Command and a Certificate.

TACTICAL AIR COMMAND

Ground Safety Man of the Month

First Lieutenant Douglas L. Pulliam, 317 Supply Squadron, Pope Air Force Base, North Carolina, has been selected to receive the TAC Ground Safety Man of the Month Award for October 1972. Lieutenant Pulliam will receive a letter of appreciation from the Commander of Tactical Air Command and a Certificate.
From a desk in a corner, a chuckle bounced around the office of TAC ATTACK followed closely by a lou
guffaw then uncontrolled laughter. The staff gathered around the assistant editor to administer aid or restraint,
obviously he had flipped his cork. He pointed to an article in the June 1967 issue of TAC ATTACK and between great
gaping giggles said, "Hey, that's great; let's run it again." So here it is. The article originally appeared in BOEING
MAGAZINE who generously granted a reprint. ED.

by Mr. Harold Dunn

Did you know that the first lady aviator was Kitty Hawk? That Roger Wilco invented the "language of
communication?" Or that one of the chief by-products of the aviation industry is going places?

This information has been gleaned from test papers and essays during the 11 years that I've taught elementary
school youngsters.

Kitty Hawk and Roger Wilco may have their admirers but Baron von Richthofen, the German ace of World War I,
has also come in for his share of adulation. A 10-year-old girl summed up her feelings like this: "In a
uniform or not, Baron von Richthofen was a dashing figure."

If history repeats itself, it usually does it with some unexpected twists when grade-school pupils tell the story:
"Spinning jennies were flying jennies that did not work."

"People talked about flying in balloons for centuries. Finally there was enough hot air to get them off the
ground."

QUESTION: On his first flight, how long was Wilbur Wright in the air?
ANSWER: I'm not sure. Five feet something with his shoes on.

One of the fringe benefits of being an elementary school teacher is the possibility that the next paper I
correct will contain a wrong answer that is twice as witty and delightful as the right one. When members of the
grade school set turn their attention to men notable in aeronautics, youngsterisms seem to come as thick as
chalkdust. Three examples:

DECEMBER 19
Roger Wilco invented the “language of communication.”

In a uniform or not, Baron von Richthofen was a dashing figure.

Back in 1924, eight men tried to fly around the world but they only ended up where they started.

Some people can tell what time it is by looking at the sun but I have never been able to make out the numbers.

When they asked him if he would like to fly to Paris, he rolled his eyes and flashed his teeth and said, “Sure.”

I know what a sextant is but I had rather not say.
`Euclid thought out how to make geometry help people to fly. He was born in the 300s and died in the 200s. That is another thing he thought out how to do. He thought out how to do it by using B.C.s.' 

"Charles Lindbergh is the most famous person in flying history and so are the Wright Brothers."

"The Wright Brothers made their first flight in 1903. 1903 was really in the 20th century but everybody was behind the times in those days."

The elementary school youngster's mind is a vast storehouse of information...half true, half false and wholly delightful. Sometimes he isn't wrong at all. It's just the way he puts it:

"During the Twenties, people started walking on airplane wings and things like that. I know it is crazy but this was before television or anything so what else was there to do?"

"Back in 1924, eight men tried to fly around the world but they only ended up where they started."

"Floyd Bennett comes from the year 1926. He is a famous aviator pecially? I don't know until I came across this in a paper: "When I first started studying about airplanes, pecally things began to happen. First I was heighted by their vast hugeness. By and by I put on my thinker and thought how important they really are. I then heaved a sigh at how it would be fun visiting at where they are made."

Much of the juvenalia that I've collected through the years has been devoted to comments about Charles Lindbergh's historic first solo flight over the Atlantic. Here are three of my favorites:

"Charles Lindbergh was the first to fly to Paris. He did it by the airplane method."

"When they asked him if he would like to fly to Paris, he rolled his eyes and flashed his teeth and said 'Sure.'"

"A straight line is the shortest distance between two points unless you are going with Lindbergh to Paris. Things are different there."

In commenting on the duties of the navigator, a girl who claimed she was one of aviation's 'starchest supports' wrote: "The navigator figures out the latitude and longitude. Latitude tells him where he is and longitude tells him how long he can stay there."

Her best friend once concluded: "The three main crewmen on a plane are the pilot, navigator and percolator."

If any of these definitions have caused Webster to turn over in his grave, he would have to do it with a smile. Here's what I mean:

"Drone is a spare name for when people cannot how to say pilotless airplane."

"When anybody says plane, what he is saying depends on whether he is saying it to a pilot or a carpenter."

"I know what a sextant is but I had rather not say."

"A visa is a passport permitting an airplane to leave the country. For round trips you need a visa versa."

One-chap absorbed the information regarding the many uses for airplanes in our modern world, but his skepticism showed: "How many uses they have for airplanes these days is more for saying than believing."

Three years later his younger sister wrote: "The number of aircraft in the world today is an absurdly large fact of a number."

Ramjets have certainly come in for their share of comments recently. The remarks have proved to be unexpected, unconventional and undeniably true: "Until it is decided whether ramjets are rockets or jets, we must continue to call them ramjets."

"The way ramjets work, as I understand it, is not very well understood."

"In ramjets the air rushes out when the fuel is ignited. So would anybody."

A couple of years ago there was a tiny moppet in my class who had a delightful way of expressing her thoughts. Here's how she summed up her feelings: "I'll have to try now on I will put both gladness and wonder in my thought about airplanes."

More than one eager young scholar has started out with a discussion of air travel and ended up in outer space. The following astronomical observations are fresh from the minds of four fourth graders:

"The North Star is, as a matter fact, almost straight north. This is quite a coincidences."

"Our Mother Earth has small poles and a large equator because of the tremendous speed as she hurdles through the space. Since we are along for the ride, we too tend to be flat at our poles and round at our equators."

"Some people can tell what time it is by looking at the sun but I have never been able to make out the numbers."

"Through the years people have guessed that Venus might be inhabited by women, dragons, or other strange creatures."

No one looks to the future as eagerly as youngsters do. Last year I received these two predictions about future air travel:

"Thanks to what we are learning from aviation, we should soon be able to look forward to having ceilings made out of fog."

"So far planes have only been able to fly in circles of no more than 360 degrees. This could be the next big breakthrough in air travel."

DECEMBER 1972
When tests are
30 Willow Grove AFR,
consequently, it's good poop for all taxiers and fliers of
cycle this HOT
Chief of Maintenance, 913th TAGp,
TO operations.
Major Edward
It expands the information contained in the Dash
suggested that flight crew personnel become
familiar with information contained in this
Wheel Brakes and Wheels During Ground
maintenance personnel, and fire department
note.
Reference your TAC Tip, "Brakes," page 21,
August 72 issue. TO 4B-1-1, "Use of Landing
Wheel Brakes and Wheels During Ground Operations," gives specific instructions to insure
adequate cooling of brakes after extensive use.
The first note on page 4 of the
4B-1-1 is referenced in the C-130A-1 on page
Wheel Brakes and Wheels During Ground
operations.
An AFTO 22 is being submitted by
this unit to include flight crew personnel in this
note.
It is also being suggested that the title of the
TO be changed to omit the statement
"... during ground operation." Much of the
information contained in this publication concerns RTOs, touch and go landings, full stops,
etc. These cannot be considered ground operations.
The technical order is only 5 pages long,
printed in large type, and is very easy to read. It is
suggested that flight crew personnel become familiar with information contained in this
publication. As a matter of information, the
4B-1-1 is referenced in the C-130A-1 on page
7-12, Use of Wheel Brakes.

Major Edward J. McNulty, USAFR
Chief of Maintenance, 913th TAGp,
Willow Grove AFR, PA.

TO 48-1-1 is applicable to all aircraft (not just C-130s).
It expands the information contained in the Dash One; consequently, it's good poop for all taxiers and fillers of
during ground operation." Much of the
information in this publication concerns RTOs, touch and go landings, full stops,
etc. These cannot be considered ground
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7-12, Use of Wheel Brakes.
### TAC TALLY

**MAJOR ACCIDENT RATE COMPARISON**

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### AIRCRAFT ACCIDENTS

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### SUMMARY

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<tr>
<td><strong>100%</strong></td>
<td>100% 100%</td>
<td>100% 75.0%</td>
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### TOTAL ACCIDENTS

- **MAJOR**: 1
- **ACCREW FATALITIES**: 1
- **ACIRRAFT DESTROYED**: 1

### TOTAL EJECTIONS

- **SUCCESSFUL EJECTIONS**: 1

### PERCENT SUCCESSFUL

- **100% 69% 83.3%**