

The Christian Party

Kara Hultgreen



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Newsgroups: sci.military.naval

Israelites From: [\[email protected\]](#) (J.D. Baldwin)

NWO Subject: [Re: The Blue Angels -- affirmative action fails again?](#)

Organization: Revealed on a need-to-know basis.

Homicide Date: Fri, 6 Oct 1995 03:47:00 GMT

Blacks

In article <[\[email protected\]](#)>, Graydon

Whites <[\[email protected\]](#)> wrote, quoting M. L. Shettle

Signatory ([\[email protected\]](#)):

Talmud >: The Blue Angels have suspended its shows due to the fact the the

>: unit's black commander is worried about his performance. Was

Watchman >: Cdr. Donnie Cochran the best man for the job or was he given the job

>: because he is black? Is this going to be another , excuse the word,

Gaelic >: "whitewash" like it was with the female F-14 pilot? Is mediocrity

Traitors >: acceptable in the interest of "political correctness" in this man's

Health? >: Navy now?

>

>Look up the report on the woman pilot.

>

>Pranged due to mechanical failure at low level and low speed; no
>cuplability, not a damn thing she could have done.

I have no opinion of or knowledge of the situation with the Blues, but this is just plain false about Kara Hultgreen. The proximate cause of the mishap was pilot error. There was an engine failure, but it wasn't fatal by itself; it had to be compounded by numerous gross errors on her part. The mishap board identified four "aircrew factors" as contributing factors to the mishap, including heavy use of rudder while single-engine (a no-no), failure to execute proper waveoff procedures, failure to inform the RIO of the emergency, and failure to make a timely decision to eject.

The Navy issued a press release stating that the "cause" of the mishap was the engine failure, and this was widely reported as Truth by the press, who--contrary to what you saw in "All the President's Men"--rarely dig any deeper than the latest press release. They did this to head off well-deserved criticism that they had rushed an under-qualified female through the program just to meet their quota in that category.

Unfortunately for the lying sacks, some disgusted junior officer with access to the Mishap Investigation Report (MIR) leaked it to "Navy Times," who put it on their forum on AOL. Not that the truth hadn't been obvious to anyone who knows a split "S" from a hole in the ground and had viewed the PLAT tapes.

Whether LT Hultgreen as an individual was underqualified and pushed into a situation for which she wasn't ready isn't *proven* by this mishap and can never be shown conclusively to be true or false. (Based on input of my LSO acquaintances, I believe it to be so, but that's a personal conclusion.) The fact that this goes on, however, is nothing short of undeniable.

I will be more than happy to mail a copy of the MIR to anyone who asks.

(Oh, and the simulator the Navy staged to "prove" that the mishap was unsurvivable was rigged. The pilots were forbidden to react properly to the emergency with which they were presented. It was then announced in another press release, widely parroted by the media, that of thirteen pilots, only the squadron CO "survived" the emergency. Forget the problems with the Blues, it looks like Johnnie Cochran is running Navy Public Affairs.)

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From the catapult of J.D. Baldwin	+ "If anyone disagrees with anything I
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70 _::)=}- for PGP public	+ retract it, but also to deny under
_/ key information.	+ oath that I ever said it." --T. Lehrer

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Newsgroups: rec.aviation.military
Subject: Yes, for the last time, the Hultgreen crash WAS pilot error (was:
Re: F-14 crash near Nashville, TN 1/2- any)
From: (J.D. Baldwin)

Date: Sun, 4 Feb 1996 04:14:22 GMT

In article <[\[email protected\]](#)>, Ken Rose

<[\[email protected\]](#)> wrote:

>According to an article in Newsweek *this* week (2/5/96 issue, pg. 71)
 > Under normal conditions, she would have washed out. two "downs" --
 > serious mistakes in training -- are usually enough to disqualify a
 > pilot. Hultgreen had four, but she still qualified, in part because
 > the Navy felt tremendous pressure to promote women after Tailhook '91.

This is true but misleading. Kara Hultgreen was a competent A-6 pilot who was way out of her depth in the Tomcat. The consensus of opinion among West Coast Navy LSO's to whom I have spoken is that there was pressure to pass her along despite serious deficiencies in handling the sheer cockpit workload in that type.

>Well, we can take your word for it, or we can trust Newsweek.

Probably neither is a good idea. In this case, Newsweek is much more on the ball than the person to whom you responded.

>Their article goes on to state:

> ... the Navy publicly defender her, claiming she died because of
 > engine failure. The brass tried to suppress a secret report blamin
 > pilot error, which was leaked to the press.

Absolutely true, and as far as I'm concerned this was one of the most shameful episodes in Naval Aviation history--eclipsing Tailhook in the blatantness and importance of the deception. The safety review process is supposed to be *sacrosanct*. NO considerations other than the facts--not friendship, not politics, not cover-the-asses-of-the-senior-officers--are relevant when determining factors contributing to the mishap. The Navy departed from this philosophy when it publicly stated that the MIR (Mishap Investigation Report) had concluded that Hultgreen's actions were not a cause of her mishap. This was a blatant lie, I can prove it, and I will be more than happy to mail a copy of the MIR to anyone who asks. (It was obtained by Navy Times and released publicly over the Navy's strenuous objections.)

It gets worse: officials on SECNAV staff (I'm not sure about that part, but it was from pretty high up and one knowledgable source said it came straight from an undersecretary) staged a phony, rigged simulation of the mishap that was nearly impossible to recover from because the pilots were prohibited from executing proper waveoff procedures. They then announced publicly that of thirteen pilots who simulated the engine failure, only one or two (I can't recall the details) "survived."

Anyway, the bottom line is this: whether Kara Hultgreen "belonged" where she was or not, we can never know for sure. Whether she committed an error that directly caused her death we *do* know with a high degree of certainty, and the answer is that she did. Anyone who tells you otherwise is in the throes of PC-mania or just plain ignorant.

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Newsgroups: rec.aviation.military
From: [\[email protected\]](#) (J.D. Baldwin)
Subject: [F-14 crash near Nashville, TN 1/2- any](#)
Date: Mon, 5 Feb 1996 23:42:13 GMT

In article <[\[email protected\]](#)>, Bomber Bill
<[\[email protected\]](#)> wrote:

>Oh for pete's sake! Blanked inlet? Look at the tape. LOOK AT THE
>TAPE! Her Tomcat is flying essentially straight when the port engine
>flames out. What rudder yaw are they claiming caused the inlet to be
>blanked?

Yell all you want, but you only drive home your (invincible?)
ignorance that much further. The LSO's on the platform and the Mishap
Investigation Board disagree with you, and I guarantee they've seen
the tape. THEY'VE SEEN THE TAPE! To wit:

MP's attempt to salvage overshooting approach with left rudder
led to reduced eng[ine] comp[ressor] stall margin, contributing
to left eng comp stall.

>Frankly, I doubt this was in the mishap report.

You know, if you just set an environment variable called USER to
"Willf L. Ignoramus," you'd save everyone else the trouble of figuring
it out by making inferences from your posts.

>Only portions of the conclusions were leaked as far as I have read and
>no specifics were offered with regard to purported pilot error.

And yet again, on two *more* counts. The entire report was released and
published by Army Times (owner of "Navy Times") and does indeed identify
numerous deficiencies on Hultgreen's part, including:

What: . . . attempted to salvage a poor approach

Why: Performance, technical error, overcontrol

What: Controlled afloat, other, performed single eng waveoff
improperly.

Why: Performance, failure of attention, distraction external, . . .
cognitive saturation.

What: Failure of aircrew coordination, failed to communicate.

Why: Performance, failure of attention, cognitive saturation, . . .
channelized attention, distraction external.

What: Failed to make timely decision [to eject].

Why: Performance, failure of attention, distraction external, . . .
channelized attention, . . . cognitive saturation.

>I kept my eye on the attributed leaks to see if she was cited for poor
>throttle handling and never saw anything about it, so unless you've
>got a cite for that I plain don't believe it.

Translation: "I've got my own preconceived notions, and damn you or
anyone else who tries to shake them!" The next step (for those
keeping score of the Flat Earth Index) will be to accuse me of making
up the above. After that (when I provide the entire MIR itself, as I

have long offered to do to anyone who e-mails), it will be to accuse me of making *that* up. (Yeah, I *wish* I had the free time to fabricate an internally consistent, nearly 55K, technical document like an MIR.)

>She is unfortunately liable to other areas of pilot error, but let's >not make things up about a US serviceman (or whatever) who died in the >line of duty.

OK, I'll promise to refrain from inventing "facts" about the incident, if you'll promise to *cease* doing so.

>This is how hearsay works, of course. Just leak vague hints and people >who want to believe them will make up their own details to support their >prejudices.

Uh-huh, I've seen this at work, too. It goes sort of like, "Anyone who would suggest that pilot error might have caused or contributed to this mishap is obviously politically motivated to denigrate Kara Hultgreen's memory, just because she was a woman." It *is* a despicable practice, isn't it?

For the benefit of anyone else incapable of distinguishing between respect for the truth and disrespect to the honorable sacrifice of a dead aviatrix, I just want to note that I have no opinion as to whether Hultgreen was pushed into the position in which she found herself despite being unqualified. There *is* some informed opinion to that effect in the West Coast naval aviation community, and it's not in serious dispute that this particularly odious form of "affirmative action" *is*, after all, a fact of life in the Navy. The fact that senior Navy officials felt compelled to *lie* about the MIR results doesn't help the "con" side of the debate much.

But even if we assume the worst about the situation surrounding her placement in F-14's, it doesn't change the fact that this was a brave and indomitable young woman of the highest character who died a tragic and honorable death in the service of her country. I had mutual friends--including a close one--with Kara Hultgreen, and it gives me no pleasure to have to point out the contents of the MIR that are less than complimentary toward her. (In particular, I'd like five or ten minutes alone with the asshole who casually referred to her as "that douche bag.") But, to use a quote from Naomi Wolf of which I'm very fond, "To suggest that the truth is in bad taste is the highest form of hypocrisy." It's hardly becoming to Hultgreen's memory to shade our eyes from the facts just because they're politically embarrassing to her ardent defenders.

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~

 Newsgroups: rec.aviation.military
 From: [\[email protected\]](#) (J.D. Baldwin)
 Subject: [Re: F-14 crash](#)

Date: Wed, 7 Feb 1996 18:54:37 GMT

In article <[\[email protected\]](#)>, Ken Rose
<[\[email protected\]](#)> wrote:

>And, curiously enough, you edited out the quotation which held that
>Hultgreen made 4 serious mistakes in a training program under which 2
>normally result in a wash-out. This is a question of fact; either she
>did or she didn't. I don't have access to her personnel records, and
>I suspect you don't either. The best I'm left to go on are public
>sources, like Newsweek.

There's a middle ground between accepting "Newsweek" at face value (an idiotic line of approach no matter how you slice it) and requiring direct access to all the relevant *raw* data. Options in this middle ground include finding *credible* sources for your assertions, or the much less popular but just as honorable shutting up about things about which you know nothing. Give one or the other a try.

Hultgreen had four "downs" in the training command. (Source: the publicly available MIR.) Two "downs" do *not* "normally result in a wash-out." I don't care what you heard from Newsweek, or the Tooth Fairy, or the little happy face on your Mac startup screen.

A second "down" flight triggers a JRB (Jacket Review Board), which has the authority to "attrite" (kick out) the student, or to retain him, on a case-by-case basis. It's rare but not unheard of for a student to be attrited after two downs (i.e., at the first JRB). I know of one student who graduated and got his wings with *eleven* downs. (This is extremely unusual.) My educated guess is that about 1/3 to 1/2 of all students who are reviewed after their fourth down flight are retained and go on to get their wings, maybe slightly fewer. It's not wildly unusual, and it's irresponsible speculation to suggest that a particular individual was obviously "unqualified" on that basis alone.

Irresponsible speculation? Newsweek gets away with it because they're owned by a powerful lady with a lot of money and influence. You don't get away with it because people who *do* know better are here to call you on it, on an equal footing in the same forum.

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Newsgroups: rec.aviation.military
From: [\[email protected\]](#) (J.D. Baldwin)
Subject: [Re: Lt. Hultgreen again](#)
Date: Tue, 6 Feb 1996 23:18:15 GMT

>>> Actually, from all I've heard, she was. Her instructors had said she was
>>> not ready, but the "powers that be" were so hot to be the first to get
>>> female fighter pilots out there that she was, in effect, sacrificed.

>

>Her records say she was a "slightly above the average" navy pilot, so there
>were no "powers" who wanted to be the first to put a woman in an F-14 seat.

>Have you ever heard they denied this seat to a male "slightly above the
>average" navy pilot?

I'd like to know where *both* of you are getting this. I've never seen an *attributed* quote about her abilities either as below or above average. There is some performance data in the MIR, but it doesn't specifically support either a finding of "above average" in raw numbers (the raw numbers, I'm guessing, are slightly below the fleet average for new Turkey drivers) or any indication of general lack of confidence in her abilities by her squadron or her peers. In fact, the MIR concludes she had a "solid reputation" and that the CO and OPS officer were "confident in [her] CQ ability."

Some facts (I apologize in advance for having the bad taste to introduce these into the discussion):

Hultgreen was disqualified during her first attempt at CQ. This is common, but not extremely common. Maybe one in ten disqualifies, maybe one in fifteen. Most (maybe 90% or even 98%) DQ's go on to qualify the second time around, as did Hultgreen. Her ranking for the CQ phase of training (second time around) was 3 of 7. Her final class rank for the whole F-14 RAG (excuse me, I mean "FRS") was 3 of 5. Classes are so small and so variable in general ability that there is no way to infer anything meaningful from overall class rank.

More specifically, her CQ performance (the first time around) was:

field: well below average
CV day: slightly below average
CV night: unsatisfactory (obviously)

Her problems could be accurately summarized as bad starts compounded with poor throttle control. Even the second time around, she had a few identifiable problems with power control, but nothing serious enough to be unsafe.

None of this changes the fact that, on October 25, 1994, she screwed up real bad and died as a result. Neither does any of it prove that she was either unqualified or supremely qualified. You know what? The record is ambiguous. You don't know, I don't know, no one *really* knows but her instructors and they're not talking. Personally, I find it very difficult to believe that Navy LSO's would pass an unsafe pilot on to the fleet regardless of political pressure, but I admit it's possible.

So speculate if you like. I've been known to do a little of that, myself. But STOP PRETENDING TO HAVE INSIDE INFORMATION when all you're really doing is re-hashing rumors. Once again, if you want the damn MIR, I'll e-mail it to you. All you have to do is drop me a note.

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~

Newsgroups: rec.aviation.military

From: [\[email protected\]](#) (J.D. Baldwin)
 Subject: Re: [1/2] Re: Lt. Hultgreen again
 Date: Fri, 16 Feb 1996 19:43:57 GMT

In article <[\[email protected\]](#)>, Andy Millon
 <[\[email protected\]](#)> wrote, quoting Paul Jonathan Adam:
 > PJA> So, if the record said she was a below-average pilot who should have
 > PJA> been grounded, you would question that on the basis that the flight
 > PJA> instructors were pressurised into saying that? Or do you only
 > PJA> disbelieve official reports when it suits you?
 >
 >There is a distinct difference between "below average" and "unqualified."
 >Somebody has to draw the line somewhere and those doing the line drawing
 >believed she met the minimum qualifications at the time they were making
 >that decision. With a more critical, post-mishap review, it becomes
 >obvious that the line was drawn too low.

Andy, thank you for your extremely intelligent additions to this thread. While "extremely intelligent" normally means "agrees with me," in this case I have a quibble: it is not "obvious that the [qualification] line was drawn too low" in Hultgreen's case. I agree that it is entirely possible and would be quite consistent with standard Navy practice in every other training activity I've observed, but the record is ambiguous in this case and we can never know for sure.

In fact, this specific possibility ("FRS failed to disqualify MP for substandard performance") was considered and rejected by the MIB. Your opinion has merit, and indeed echoes the opinions of a lot of West Coast LSO's and pilots, but it's not that clear an issue that you can go around calling it "obvious."

> PJA> Now, either the entire Navy is willingly lying in published
 > PJA> documents, or she was a competent pilot.
 >
 >"Competent." Just what is "competent?" The MIR does not define the
 >word, ney, it doesn't even use the word. Neither does USN aviation
 >which operates under the "qualified/not qualified" standards. In this
 >case, the MP was qualified -- below average, but above the minimum
 >qualification standards at the time.

An excellent response, but it needs to be noted that the MIR is *not* a "published" document and has only been made available because the Navy *did* see fit to lie in a press release on the subject. Presumably someone with access to the report was disgusted by this and decided that the truth ought to be known and he no longer owed confidentiality to an organization that would so blatantly and cheaply breach its honor in such a manner. So it came into the possession of "Navy Times," who made it available online.

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 ***~-----

From: [\[email protected\]](#) (J.D. Baldwin)
 Message-Id: <[\[email protected\]](#)>

To: yarvin-norman
 Subject: Re: The Blue Angels -- affirmative action fails again?

My pleasure. Enjoy wading through acronym hell.

jd

F-14A Mishap Investigation Report

(Military City Online note: This is the Mishap Investigation Report into the Oct. 25, 1994, crash that killed a Navy F- 14A Tomcat fighter pilot, Lt. Kara Hultgreen. The report, which was released only to a limited number of members of the aviation community, includes a list of acronyms used in the text.)

1. Summary: Aircraft impacted water during day CV landing approach. Aircraft destroyed.

2. Data.

A. Aircraft. (1) F-14A, (2) 160390, (3) 103, (4) VF-213.

B. Equipment. (1) drop tank (two), (2) Grumman, (3) A51P7100-27, (4) AFWA.

C. Environment. (1) 25 Oct 94, (2) 1501, (3) t, (4) day,
 (5) 32 04.2N/117 27.2W, NZY 190 Radial/41 DME, off coast of San Diego, Ca.
 (6) sea level, (7) 20 ovc 10, wind 310/15, altimeter 30.01.

3. Circumstances.

A. Origin. NAS Miramar

B. Mission. CQ refresher

C. FLT purpose code. 1A4.

D. Type of flight plan. IFR, VMC.

E. Destination. USS Abraham Lincoln (CVN-72).

F. Aircraft evolution. CV landing.

4. Mishap category. Class a flight mishap, aircraft destroyed.

5. Damage and costs.

A. Aircraft.

1. F-14A, 160390, destroyed.

B. DoD property damage. Two drop tanks, \$111,900.

C. Non DoD property damage. none.

6. Personnel information, injuries and costs.

A. Souls on board. two.

B. Crew. Pilot at controls, LT, 1310, USN, VF-213, on duty, fatal injury, NVGS not used, 1241.9 total hrs, 217.9 F- 14A hrs- RIO, LT 1320, USN VF-213, on duty, first aid injury, NVGS not used, 697.7 total hrs, 477.1 F-14A hrs.

C. Total number of passengers. None.

D. Injured non-occupants. None.

7. Mishap investigation. AMB investigation complete.

8. JAG manual investigation. This mishap does meet the requirements in ref b for a JAG manual investigation. JAG investigation complete 14 feb 95.

9. Point of contact.

A. Aircraft mishap board.

- Senior member: Cmdr. S.E. Luce, USN, VS-29, DSN: 7350820, COMM: (619) 545-0820

- Aircraft maintenance: Lt N.P. Jennings, USN, VF-213

- Aircraft operations: Lt.Cmdr. J.S. Bates, USN, VF-213

- Aviation safety: Lt. M.B. Whetstone, USN, VF-213

- Aviation Safety: Lt J.A. Tekverk, USN, VS-29

- flight surgeon: Lt S.M. Miller, USN, CVW-11, DSN: 577 4669, COMM: (619) 537-4669

B. Telephone inquiries. VF-213: DSN: 577-4526, COMM: (619) 537-4526(619) 537-45

10. Evidence.

A. Enclosures [[REMOVED]]

B. Summary of Evidence.

(1) The following acronyms are used in this msg: [[REMOVED]]
WUOSX - wrapped up overshooting start

(2) Definitions [[REMOVED]]

(3) Aircrew data

(A) MP was first operational tour naval aviator with 1241.9 total FLT hrs including 217.9 F-14A flt hrs. MP had total of 58 carrier landings: 48 F-14A carrier landings (31 day and 17 night). MP assigned to MS 30 Aug 94. Primary billet assignment was public affairs officer. (3a,4a)

(B) MP had flown 25.4 hrs in last 30 days, and 8.5 hrs in last 7 days. Last carrier landing was 30 Aug 94. last FLT prior to MF was 24 Oct 94. (3A)

(C) MR was a first operational-tour naval flight officer with 697.7 total FLT hrs including 477.1 F-14A FLT hrs. MR had a total of 150 carrier landings (80 day and 70 night) all in F-14A. MR assigned to MS 04 Jan 93. Primary billet assignment was assistant line division officer. (3A,4A)

(D) MR had flown 20.7 hrs during last 30 days, and 6.7 hrs in last 7 days. last carrier landing was 24 Aug 94. Last FLT prior to MF was 24 Oct 94. (3A)

(E) (P) MP last documented act was 17 may 90. However, interviews confirm MP completed act during FRS syllabus. FRS act is not documented. (5A)

(F) MR completed annual act in MS Mar 94. (5A)

(G) MP and MR were crewed 12 Oct 94, and flew ight sorties together prior to MF, completing 9.4 FLT hrs, 2.3 day/7.1 night. MC had no CV landings as a crew. MP and MR last FLT together prior to MF was a 1.1 hr FCLP flight, 24 Oct 94. (3A)

(H) MP and MR were fully qualified for MF iaw all applicable directives. (5A)

(I) MF was authorized by the MS commanding officer per ref D. (6A)

(4) LSO data

(A) CLSO was wing and training qualified CVW staff LSO (A-6 background); wing qualified Jan 91, training qualified Oct 91. (7a)

(B) BLSO was wing, training, and staff qualified CVW staff LSO (E-2 background); wing qualified Jul 91, training qualified Aug 92. (7A)

(C) (P) BLSO was familiar with MP's landing performance. (5b)

(D) MS LSO structure consisted of one experienced wing qualified LSO.

(5) Aircraft data

(A) MA had flown six sorties/7.3 FLT hrs in previous seven days and 28 sorties/41.5 FLT hrs in previous 30 days.

(B) MA maintenance record audit found the following pertinent maintenance actions entered and outstanding at time of MF: (1) discrepancy: R/C A/S three knots slower than F/C A/S and computed landing A/S at optimum (on speed) AOA.

(2) Discrepancy: left engine AB takes five sec to stage. Right engine operates normally.

(3) Discrepancy: throttles go to manual upon deselecting AB.

(C) (P) MA basic weight was 44,700 pounds. F-14A NATOPS (ref C) maximum CV landing weight is 54,000 pounds. MR testimony states fuel weight was 9,000 pounds at time of mishap; MA total approach weight was 53,700 pounds.

(3B)

(d) F-14A NATOPS (ref C), Fig 11-9 indicates approach speed for a 53,700 pound F-14A with modified DLC in the neutral position (engaged) is 139 KIAS.

(6) Aeromedical data

(A) MP and MR had current FLT physicals and valid aeromedical clearance

notices. (5A)

(B) (P) MC had unremarkable 72 hour histories with adequate rest preceding MF.

MP had approximately 7.5 hrs of sleep the night prior to the MF. MP awakened at 0700. At time of mishap MP had a 3.5 hour duty day. (2B)

(C) (P) MR was located floating approximately 200 yards off ship's port quarter. MR rescue by SH-60 occurred four minutes 29 seconds after ejection. MR transported to CV medical department for observation. MR's injuries detailed in AA. (8A, 17A, 2B)

(D) MP recovered from ocean bottom 19 days after mishap. MP still attached to ejection seat by lap belts. MP's injuries detailed in AA.

(7) Aviators life support system data.

(A) MP FLT gear was recovered with MP and ejection seat after 19 days immersion in salt water. FLT gear was intact, and MP was attached to ejection seat by lap belts. Seawars activated properly. MP ALSS inspection revealed LPU inflation occurred automatically. MP upper right lobe of LPU did not inflate.

(B) MP helmet and portion of mask recovered after mishap. Minor impact damage

to MP helmet; left oxygen mask bayonet receiver upper cover plate missing;

center oxygen mask, and MIC assembly and hose separated from mask. Right bayonet fitting/attachment remained intact.

(C) (P) MR statements reveal right seawars failed to actuate on water entry. MR manually released right upper koch fitting. Safety center data indicate

10 of 73 seawars failed from 1980 to 1994 in F-14A community. (3B)

(D) (P) MR retained helmet/mask during ejection. Inspection revealed no pertinent discrepancies. (3B, 9B, 20B)

(E) (P) MP ejection seat recovered. EI revealed the following: all explosives, except the guillotine cartridge, functioned properly. Harness reel straps fully retracted and released via the time release mechanism. Water impact damage interrupted the normal mechanism and prevented survival kit lugs and leg restraint locks from releasing. Leg restraint lines subsequently released by outward

distortion

of seat bucket sides upon water impact. (9A, 23A, 12B)

(F) MR ejection seat recovered. seat functioned properly. EI not required.

(G) (P) MR has excellent recall of ejection sequence, including activation utilizing lower ejection handle, canopy separation, seat/man separation and water entry. (3b)

(8) Chronology

(A) (P) All times local. times from 0700 to 1457 are approximate. (17A, 2B, 3B, 4B, 5B, 9B) 07:00 - MP awakes. 07:30 - MR awakes.

11:45 - MR arrives at squadron.

12:15 - MC begin brief for FLT.

13:05 - MC proceeds to review ADB/preflight MA.

14:00 - MA takes off.

14:34 - MA established in marshall with 16,000 pounds fuel.

14:44 - MP dumps fuel to 12,800 pounds total remaining.

14:54 - MA commences approach from marshall.

14:57 - MP dumps fuel to approx 10,000 pounds.

15:00:15 - A/C 116 (flight lead) FD WO.

15:01:01 - MP arrived at ninety, 450' MSL, 145-148 kts, 100 FPM rod.

15:01:03 - MP responded to MR ICS ``you're five kts fast'' with ``roger.''

15:01:05 - MR, ``103 tomcat ball, Hultgreen.''

15:01:06 - MA crosses wake of ship. MR hears almost imperceptible ``pop'' from

MA. MR ICS, ``you're on speed.''

15:01:07 - CLSO, ``roger ball.'
 15:01:10 - MA crosses (overshoots) extended landing area centerline. MR, ICS, ``we're 10 knots slow, let's get some power on the jet.'
 15:01:11 - MA wings level. black smoke trail from ma right eng only.
 15:01:13 - Black smoke trail from ma starts to fade.
 15:01:14 - BLSO, ``waveoff,' and activates wave-off lights.
 15:01:14 - CLSO transmits, ``waveoff, waveoff.' cutting out BLSO's ``level your wings and climb' call. 15:01:16 - bLSO, ``waveoff,' MA crosses extended landing area centerline from MA right to left. Black smoke trail from MA disappears. 15:01:17 - BLSO, ``power.'
 15:01:18 - BLSO, ``raise your gear.'
 15:01:19 - BLSO, ``raise your gear.'
 15:01:20 - BLSO, ``power.'
 15:01:20 - MA, from wings level, begins approx 90 deg/sec left roll.
 15:01:21 - CLSO, ``eject, eject.' MA approx 50 deg left wing down and 10 deg nose down as ejection is initiated. MR ejection occurs at approx 10 deg left AOB, still 10 deg nose down.
 15:01:22 - MP ejection occurs when MA approx 110 deg left AOB, approx 25 deg nose down.
 15:01:23 - MA impacts water approx 70 deg nose down and approx 165 deg left AOB. MR separates from ejection seat.
 15:01:24 - MR chute fully deployed.
 15:01:25 - Air boss, ``where is the plane guard?'
 15:01:26 - Plane guard, ``inbound.'
 15:01:27 - MR enters water.
 15:01:29 - CLSO, ``99 delta.'
 15:03:18 - First helo on top MR.
 15:05:43 - Second helo on top MA.
 15:05:52 - Rescue swimmer and MR out of water.//

(A) MP designated naval aviator Aug 1989. MP reported to VA 42, east coast A-6 FRS Jan 90. MP served in VAQ 33 from Apr 90 to May 93 accumulating over 700 hrs in the A-6E and EA-6. MP reported to west coast F-14 FRS, VF-124, 22 Jun 93. FRS performance ranking by phase was: 2 of 5 FAM, 3 of 5 BWEPS, 4 of 5 CW/GUNS, 2 of 5 tactics, 1 of 5 ADFAS, 1 of 5 air refuel, and 3 of 7 CQ. MP disqualified during initial CQ, Apr 94. MP successfully completed CQ phase in Jul 94. MP completed VF-124 with number 3 of 5 class ranking. (5a, 10a, 11a)

(B) MP performed over 170 FCLP approaches in preparation for first CQ attempt. FCLP GPA was 2.82. although INC, MP disqualified for night GPA and boarding rate during initial FRS CQ attempt in Apr 94. MP ranked 8 of 9 with GPA/boarding rate as follows: day 2.79/79 percent, night 2.32(inc)/64 percent, overall 2.62/73 percent. AIRPAC CQ GPA/boarding rate qualification minima ARE 2.60/60 percent in each phase: day/night/overall. (11a)

(C) (P) MP's first FRS CQ RIO instructor stated MP was highly motivated during CQ phase and remained positive following DQ. Evaluation of MP by FRS CQ phase leader showed well below average field performance, slightly below average day CV performance, and unsatisfactory CV night performance. First CQ (day) trends reveal sporadic glideslope deviations due to untimely power corrections, and angling starts (11a, 7b, 8b)

(D) (p) From Jun 92 to Sep 94, 69 pilots attempted CQ at VF-124. qualification results as follows: 51 pilots qualified during initial attempt, 17 pilots disqualified first attempt and qualified second attempt, one pilot required third attempt to qualify. First attempt DQ rate is approximately 25 percent. each pilot successfully completed FRS syllabus. East coast FRS percentages are nearly identical.

(E) MP flew more than 170 FCLP approaches during preparation for second FRS CQ attempt. FCLP GPA was 3.24. MP qualified during second FRS CQ attempt in Jul 94. MP ranked 3 of 7 with GPA/boarding rate as follows: day 3.22/89

percent, night 2.82/71 percent, overall 3.05/81 percent. (11a)

(F) (P) qualifying FRS RIO instructor stated MP was safe and consistent.

evaluation of MP by FRS CQ phase leader showed average field performance, above average CV day performance, average CV night performance, and slightly above average overall CQ phase performance. Second CQ (day) trends reveal Solid pattern work, and overpowered starts with timely corrections. (11a, 7b, 8b) (G) MP last documented act was 17 May 90 in VAQ-33. (5a)

(H)(P) MP attended annual act at FRS, which was documented. (5a)

(I) MR attended annual act training Mar 94 at MS.

(5a)

(J) F-14A aircrew act consists of standard syllabus developed by interscience America and includes comprehensive lessons on: message/ feedback, importance of communication, situations requiring adaptability/flexibility, etc.

(K) (P) MP performed three practice emergency FCLP flights during four months prior to MF, two during FRS training, and one in MS prior to previous at-sea period. Each flight included two simulated single engine approaches.

(L) (P) FRS syllabus includes SSE waveoff practice during FCLP's. Records were unavailable to confirm MP received SSE waveoff practice in FRS.

additionally, interviews and records indicate MP performed no SSE waveoff practice while attached to MS.

(M) (P) Interviews with naval safety school revealed no history of F-14A eng comp stall in landing pattern.

(N) MP completed TSTA III (25-30 Aug 94) aboard USS Abraham Lincoln (CVN-72) while TAD to MS from FRS. MP performed 12 carrier approaches; seven day and five night. First six landings were day/night CQ: four day passes were case III straight-in approaches, two touch and go's, two traps; and last two were night traps. CQ GPA/boarding rate was 3.00/100 percent. MP flew six TSTA III operational passes, four day/two night for a GPA/boarding rate of 3.17/100 percent. Three day passes were case I pattern. Performance on the six post-CQ landings placed MP in approx top half of all air wing pilots. MP was top MS nugget for the line period 28 Aug to 25 Oct 94. (11a, - 13a, 21a)

(O) MP completed CVW-11 Fallon detachment 07 Oct 94 and subsequently completed eight FCLP periods in preparation for COMPTUEX 95-1A which began 25 Oct 94. MP received favorable comments from MS LSO concerning FCLP periods. Additionally, MP completed two simulators and four CQ/LSO training lectures.

During one simulator, MP flew one single engine approach. No SSE waveoff practice was performed. Lecture topics included MOVLAS, CV OPS, phraseology, and CQ procedures. (11a) (P) MR had 464.4 F-14A flt hrs as of 30 Sep 94.

Nine MS RIO's had more F- 14 flight time than MR. (22a)

(Q) (P) MR was cruise experienced and had the trust and confidence of the command. MR earned NATOPS instructor and PMCF RIO quals and was regularly scheduled to fly with vip/guest pilots. (5a)

(R) (p) MS COO and OPS officer considered MC a competent crew pairing. MS COO and OPS officer were confident in MP's CQ ability.

(S) MC began flying together 12 oct 94. MC had a total of 8 sorties/9.4 flt hrs as a crew prior to mf. All sorties were FCLP missions at nx and nuc.

(3a)

(T) (P) MC received complete and thorough CQ brief and section brief, and briefed as a crew prior to MF. MC briefed single eng during catapult launch, and low altitude ejection procedures. (3b, 9b)

(U) (P) MA had proper daily and turnaround inspections and was configured for CV landings. MA had no downing discrepancies and was properly released safe for flight. (20a, 10b)

(V) R/C A/S discrepancy of three kts slow at on speed was within acceptable limits IAW MS sop. (12a)

(W) (P) Left eng AB time to stage, though slow at five seconds, was within acceptable limits for flight.

(X) (P) MC was wingman in two-plane formation entering CV landing pattern for case III recovery. (9b)

(Y) (P) MP performed normal CV break at approx three NM upwind. MC recognized wide abeam position on downwind leg and made correction arriving slightly close abeam at 1.0 NM, approx 570 ft MSL. (3b)

(Z) (P) MA was noted slightly close abeam by BLSO. (5b)

(AA) (P) MR had avia selected on TID. (3b)

(AB) (P) MA extended slightly past abeam to correct for close abeam. (3b)

(AC) (P) MA flew approx 10 kts above computed on speed during initial portion of approach turn. (3b)

(AD) (P) MA flew approx 100 FPM rod until ninety. (3b)

(AE) (P) MC had ICS cold MIC selected during approach. (3b)

(AF) (P) MA arrived at ninety approx 450 ft MSL, 145-148 kias. (3b)

(AG) (P) Two seconds later MR ICS comm ``you're five knots fast'' was acknowledged by MP with ``Roger.'' MP did not TXMT on ICS throughout the remainder of MF. (3b)

(AH) MS SOP states, ``aircrew will acknowledge all ICS calls from the other cockpit.'' (12a)

(AI) (P) MA maintained approx 100 FPM rod until forty-five. (3b)

(AJ) (P) MA approach appeared normal through forty five. (3b, 4b, 5b)

(AK) (P) Witness statements confirm MA was in proper configuration for arrested CV landing. (3b, 4b, 5b)

(AL) (P) As MA crossed ship's wake, MR noted MA five kts fast. During post-mishap recollection MR recalled hearing an almost imperceptible ``pop'', described as ``popcorn stall'' type of sound. (3b)

(AM) (P) MA flew WUOSX, 42 to 45 DEG AOB. (13a, 17a, 4b, 5b)

(AN) (P) CLSO and BLSO observed excessive left YAW on MA; attributed to perceived use of rudder to avoid overshoot. (4b, 5b) (AO) (P) MA rolled out wings level at start, on speed, 325 feet agl, with 400 FPM rod and on glideslope. (3b)

(AP) (P) MR scanned centered ball, then noticed MA five knots slow; looked outside again, then noticed MA ten knots slow. (3b)

(AQ) (P) MR advised mp ``we're ten kts slow, let's get some power on the jet.'' MP did not verbally acknowledge, but MP added power. (3b) (AR) (P) MR states aircraft started to YAW left. (3b)

(AS) (P) MA waved off by BLSO for WUOSX with left YAW. ``Waveoff'' was echoed by CLSO cutting out BLSO's ``level your wings and climb.'' BLSO subsequently transmitted ``power, raise your gear, raise your gear, power.'' ``burner'' call was not used by LSO. ``Burner'' is a standard imperative LSO phrase. (17a, 4b, 5b)

(AT) (P) AB plume was visible from MA right engine only. (9b, 13b)

(AU) (P) MR did not recall hearing ``raise your gear'' calls. MR heard only ``waveoff'' and ``power'' comm from LSO's and does not recall any subsequent LSO comm. (3b)

(AV) (P) U.S. Navy LSO school, ILARTS analysis states, ``...just after the start position the LSO (BLSO) felt the approach was not within standards and tried to remedy the situation with an early waveoff call.'' Additionally, analysis states, ``All calls ... were timely and necessary.'' (11b)

(AW) F-14A NATOPS manual (ref c), chapter 15 landing emergencies, page v-15-1, single engine landing, states: ``single-engine landing, bolter, or waveoff may be accomplished safely up to the gross weight limits for two-engine operation. ``during waveoffs or bolters, select mil thrust, rotate not to exceed 14 units AOA as for normal two engine takeoff ... ; page v-15-2, ``warning extreme caution must be exercised when performing turns into a dead engine. Decaying Airspeed/increasing AOA can rapidly result in a situation where there is not enough rudder authority to return the aircraft to level flight, and insufficient altitude to effect a recovery ``warning - military power climb performance during heavy waveoffs may not adequately arrest high sink rate conditions. Use of full AB provides a significant

increase in climb performance. Up to full rudder may be required to counter AB asymmetric thrust yawing moment during waveoff or bolter. Do not exceed 14 units aoa during waveoff or bolter.'

(AX) F-14A NATOPS manual, page IV-11-23, asymmetric thrust flight characteristics, landing configuration, states: ``steep angle of bank turns, particularly into the dead engine, reduce climb performance and may result in rudder requirements exceeding available control deflection causing loss of control.'';

And, ``if AB is used, the pilot should be prepared to use up to full rudder to counter the large YAW moment produced. Late rudder application that allows sideslip buildup may result in loss of aircraft control even with full rudder. Lateral stick should not be used alone to counter yawing moment.

However, if lateral stick is used, it should be applied coincidental with or after rudder inputs. A maximum of 14 units AOA should be used on all waveoffs since rotation to higher AOA does not significantly reduce sink rates...'

(AY) (P) BLSO noticed MA nose slowly rotating up as if mp was attempting to arrest rate of descent with nose attitude vice power. (5b)

(AZ) (P) MA right spoilers were fully deflected up, left spoilers were flush. (9b)

(BA) (P) recording LSO observed MA rudders deflected full right during final seven seconds prior to water impact. (6b)

(BB) F-14A NATOPS manual, page 1-2-119, states ``landing gear retraction takes nominally 9-15 seconds.'

(BC) (P) There is no evidence to indicate MP attempted to retract MA landing gear. (17a, 2b)

(BD) (P) Mr felt MA was under control and was going to successfully fly away. (3b)

(BE) (P) simulator tests duplicating MF reveal that MA was controllable up to 20 units AOA. Above 20 units AOA, aircraft was uncontrollable and departed controlled flight with rapid left roll off. (13b)

(BF) (P) MA rapidly rolled left wing down. (17a, 3b, 13b)

(BG) F-14A NATOPS manual (ref c), chapter 16 ejection and bailout, p. v-16-1 states ``responsibility for the decision to eject shall be determined and briefed prior to flight. Thereafter the decision to abandon The aircraft shall rest with the crewmember assigned responsibility for that particular situation.' Additionally, REF C states ``in each case, the pilot must decide when to eject...'

(BH) (P) during final seconds of MF, MR was externally evaluating ejection criteria relative to CV flight deck elevation. If MA descended below flight deck level, MR was going to eject MC. (3b)

(BI) (P) MC flew with eject command lever in command mode allowing MP or MR to eject both crew. (3b)

(BJ) F-14A NATOPS manual, pg 1-2-157, states that ``command ejection by either crewmember will eject the rio first and the pilot 0.4 seconds later. Total time for ejection is 0.9 seconds.' F-14A NATOPS manual, pg 1-2-156, states ``ejection trajectories are canted laterally to provide additional separation of the seats. The RIO is ejected to the right and the pilot to the left.'

(BK) (P) MR initiated ejection upon commencement of MA left roll. (3b)

(BL) (P) MA canopy jettisoned with MA at approx 50 deg aob. (17a)

(BM) (P) MR rocket motor initiated with MA approx 90 deg AOB/10 deg nose down, approx 65 ft MSL. (17a)

(BN) (P) MR safely ejected and achieved normal parachute deceleration, entering water approx 300 yards off CV port aft quarter.

(BO) (P) MP rocket motor initiated with MA approx 110 deg AOB/25 deg nose down, approx 55 ft MSL. MP rocket motor burn completed with MA approx 135 deg AOB/35 deg nose down. (17a)

(BP) (P) MP did not achieve seat-man separation prior to water impact.

(BQ) (P) Water impact damage interrupted normal MP ejection seat operation. Water impact speed estimated at 235 ft/sec. (9a, 12b)

(BR) (P) MA impacted water at approx 165 deg left aob, 70 deg nose down. MA came to rest upright approx 120 deg clockwise from initial approach heading. (17a)

(BS) During MA final approach CV was maintaining 15 kts and turning slightly left from 333 to 330 deg true hdg. (8a)

(BT) (P) Flt deck winds were down the angle at 2527 kts. (4b)

(BU) Weather at time of mishap: estimated 2000 ft overcast, visibility 10 sm, wind 310/15 kts, altimeter 30.01, outside air temperature 65 deg f, sea state 1. (18a)

(BV) (P) MR and MP had good ICS and UHF comm during entire flt. (3b)

(BW) In the tf30 engine the smallest stall margin exists for stages 4-9 of the N-1 (low pressure) compressor. (14a)

(BX) F-14A NATOPS (ref c), pg I-2-16 states: MCB bleed air is ported from the seventh stage of the low pressure compressor into the fan bypass duct during certain flight parameters in order to increase eng comp stall margin.

(BY) (P) MCB test lights are located on the MCB Test panel in the R/C. Illumination of the lights indicates only that the electrical circuits are operating, but does not verify MCB operation. MCB test panel normally in off position except during PMCF.

(BZ) Left eng MCB system was stuck in the bleeds closed position prior to impact, preventing seventh stage bleed air from being ported into the fan bypass. This condition was caused by a failed directional control linear bleed control valve (solenoid) assembly. Particularly, disassembly of the directional control linear bleed valve assembly revealed the pin was stuck in the spacer stop, the plunger was stuck in the solenoid, and the solenoid valve was stuck in the liner. The pin, spacer stop, solenoid valve and top of the plunger (it remained stuck in the solenoid) were found to be caked with a dark powder like debris. The debris Examined was consistent with wear generated particles of the components' nickel plating and wear generated particles of the parent metals. There was no evidence of contamination of the assembly by lubricants. (14a)

(CA) (P) Full operation of MA left engine was last checked during test trim run at hot section inspection/change, 601 operating hrs prior to MF. MCB system was operating properly at that time.

(CB) (P) MCB system had been stuck in bleeds closed position an undetermined period of time.

(CC) (P) discussion with NADEP engineers reveals that eng stall margin increase gained with MCB system open vice closed varies from 23 per cent at idle to 26 per cent at mid power (8283 per cent) to 18 per cent at military power although stall margin remains marginal (14b).

(CD) TF30-P-414A eng stall margin may be checked on Preinduction or troubleshooting test cell runs. (14a)

(CE) (P) F-14A TF-30 engine hot sections are changed no later than 750 hrs of operation. Only 25 per cent of Tf-30 engine hot sections remain in service beyond 600 hours of operation. They are removed for various reasons: fod, turbine failure, high oil consumption, etc. Information is based on two and one half years data ended summer 1994 at NADEP Norfolk, Va and contains approx 400 data points.

(CF) F-14A NATOPS (REF C), pg IV-11-4, para 11.4.2.1 states ``The engines generally operate satisfactorily at extremely high positive or negative AOA but are prone to compressor stalls if high AOA is combined with sideslip ... or throttle settings below 90 percent RPM.... Each of these conditions reduces the engine's compressor stall margin, which is already reduced when operating at high AOA. Excessive sideslip, even at low AOA, may result in compressor stalls anywhere in the aircraft flight envelope.''. ``There is no way to predict when a compressor stall will occur, but there is a likelihood of inducing one by changing throttle settings at high AOA.'

(CG) F-14A NATOPS (ref C), pg IV-11-5, para 11.4.2.4 states: ``warning. stall on one eng while maneuvering at low airspeed must be dealt with immediately, since flight control effectiveness may be insufficient to counter the YAW rate generated by asymmetric thrust.''

(CH) F-14A NATOPS (ref c), pg IV-11-5, para 11.4.2.2 states, ``Subsonic compressor stalls are characterized by an RPM decrease and an increase in TIT. They may produce an audible thump or bang, or they may be inaudible.''

(END PART ONE)

(continued)

(CI) Both left and right fuel shutoff valves in eng nacelle were confirmed in the open (normal) position. (14a)

(CJ) Both left and right eng fuel feed systems showed no evidence of preimpact failure. Analysis of fuel recovered from various Locations in the engine accessory components indicated JP5 contaminated only with salt water due to long immersion in ocean. (14a) (CK) there was no evidence of fod ingestion in the leading edge on the inlet guide vanes on either eng. (14a)

(CL) There was no airfoil damage on the N-1 (low speed) turbine assembly or on the turbine exit vanes on either eng. (14a)

(CM) Left eng combustion (hot section) components revealed normal thermal deterioration for the 601 hours since last hot section (750 hour) inspection. (14a)

(CN) Left eng main bearing packages indicated no preimpact discrepancies. (14a)

(CO) Left eng mfc was properly trimmed and did not reveal evidence of physical deterioration of internal working components. (14a) (cp) left eng first stage turbine blade thermal analysis indicated leading edge temp for The blades was determined to be in the 2000 to 2100 deg F range. Normal leading edge temp for TF30-P-414A turbine blades are in the 1800-1900 deg F range. The depot rejection criteria for overtemp is 2050 deg F.

(CQ) (P) The left eng hot section would not have passed its 750 hour hot section inspection, due to overtemp condition. (14a)

(CR) elevated first stage turbine blade temp can result from engine stall conditions (any cause) as well as overtrim, TT5 limiter malfunction, turbine failures, loss of cooling airflow to the turbine assembly, etc. Once turbine blade microstructure has been changed to reflect an overtemp condition it will remain in that state. Therefore, it is impossible to determine when or how often the above normal first stage blade temp occurred. (14a)

(CS) Left eng N-1 rotor ASSY RPM was estimated to be between 40 percent minimum and 70-75 percent maximum. Left eng N-2 rotor assembly RPM was estimated to be between 65 percent minimum and 80-85 percent maximum.

Typical rotor speeds at idle are approx 45 percent N-1 RPM and 70 percent N-2 rpm. (14a)

(CT) EI could not determine if the N-1 and N-2 rotor speeds were matched aerodynamically (normal operation) or in a stalled condition (aerodynamically mis-matched rotors/ aerodynamically unstable rotors) prior to or at impact. (14a)

(CU) The left eng was found to be fully capable of producing normal power at impact. (14a)

(CV) There were no performance related discrepancies found on the right eng during ei. (14a)

(CW) Right eng last throttle input was for zone five AB operation and eng was operating normally and staged in zone five AB at impact. (14a)

(CX) Both left and right AICS inlet ramp actuators were intact and in the fully stowed (retracted) position; normal for landing configuration, low speed, subsonic flight. (19a)

(CA) Horizontal tail authority mechanism was intact and in the unrestricted position. (19a)

(DA) at time of impact, aircraft wings were in their full forward (twenty degree) position; wing flaps and slats were symmetrically and fully extended in the landing configuration; and primary flight controls were operating normally. (19a)

(DB) engine stall warning/overtemperature detection is provided to the pilot via two flashing stall lights (left stall, right stall) located on either side of the heads up display and is coupled with an audible tone in the pilot's headset. the detection system is activated when:

- (1) TIT temperature exceeds 1215 deg C, or
- (2) The ratio of TIT temperature (deg C) to low-pressure fan speed (percent nl) exceeds 17 (deg c/percent nl)., (19a)

(dc) (P) the tf-30 engine can be in a stalled condition without illumination of the engine stall warning lights.

11. analysis.

a. Aircrew factor - MC were not adequately rested for MF. Rejected. MP and MR AA and 72 hour history indicate both received sufficient rest and nourishment prior to MF.

b. Aircrew factor - MC violated MS SOP/NATOPS by failing to conduct adequate flight brief. Rejected. Witness statements indicate thorough briefs were conducted by division lead, section lead, and MC. MC discussed single eng catapult procedures and low altitude ejection scenarios in their crew brief.

c. Aircrew factor - MC failed to complete proper landing checklist. Rejected.

All available evidence including witness statements, MR statement, ILARTS analysis, and EI of recovered airframe indicate MA was in proper landing configuration.

D. Aircrew factor - MP's attempt to salvage overshooting approach with left rudder led to reduced eng comp stall margin, contributing to left eng comp stall. Accepted. CLSO and BLSO perceived MA left rudder input during WUOSX.

Stall margin was already reduced up to 26 percent on left engine due to MCB system stuck in bleeds closed position. F-14A NATOPS manual (ref C), pg IV-11-4, para 11.4.2.1 states: ``excessive sideslip, even at low AOA, may result in compressor stalls anywhere in the aircraft flight envelope.'' and, ``TF30 engines are prone to compressor stalls if high AOA is combined with sideslip.'' MP was adjusting throttle settings in normal course of the approach to decelerate ma to wings level on speed of 139 KIAS from 145-148 KIAS at the ninety. MA AOB during WUOSX was 42 to 45 deg. AMB believes MP applied left rudder in attempt to correct for overshooting start.

Overcontrol of MA, reduced throttle setting, and sideslip, combined with the MCB stuck in bleeds closed position contributed to comp stall of the left eng. Based upon above analysis, AMB concludes MP overcontrolled MA in attempt to salvage overshooting approach with left rudder, leading to decreased eng stall margin and contributed to left eng comp stall.

Who: Aircrew, pilot at controls

What: Aircrew, landing phase, LSO

Controlled, afloat, attempted to

Salvage a poor approach

Why: performance, technical error, overcontrol

E. Aircrew factor - MP failed to execute proper single eng Waveoff procedures. Accepted. Analysis shows MA departed controlled flight at approx 20 units AOA, approx six seconds after waveoff. F-14A NATOPS (ref C), pg V-15-2, states the following warning regarding single eng waveoff:

``...do not exceed 14 units AOA during waveoff or bolter. Simulator tests verify MA was controllable to 20 units AOA, however when 20 units was exceeded, departure rapidly occurred. AMB believes MP-was distracted by MA close proximity to water, and by efforts to determine engine status, and suffered breakdown in scan. MR did not see any illuminated eng stall warning lights. AMB believes left eng stall warning light was not illuminated. MP's

selection of AB and input of right stick and full right rudder to counter roll and YAW from asymmetric thrust led to task saturation. MP allowed MA pitch attitude to slowly increase with addition of power vice referencing AOA for proper single eng waveoff procedures. F-14 NATOPS (ref C), p V-15-1 states, "single engine ... waveoff may be accomplished safely up to the gross weight limits for two engine operation." Based on above analysis, AMB concludes MP failed to follow NATOPS single eng waveoff procedures, exceeded maximum safe AOA, and allowed ma to depart controlled flight at an unrecoverable altitude, due to external distraction and cognitive saturation.

Who: Aircrew, pilot at controls.

What: Aircrew, landing phase, LSO

Controlled afloat, other, performed

Single eng waveoff improperly.

Why: Performance, failure of attention, distraction external.

Why: Performance, failure of attention, cognitive saturation.

F. Aircrew factor - MP failed to inform mr of single eng emergency.

accepted. R/C has no engine instrumentation. MP did not disclose MA emergency to MR. MP had received F-14A act at FRS which included importance of communication. MP's last ICS comm acknowledged MR ICS COMM at ninety.

AMB believes MP was analyzing eng indications and aircraft status during final approach. MR did not see any illuminated eng stall warning lights.

AMB believes MP became distracted by low altitude and left YAW during waveoff attempt and failed to communicate emergency to MR due to channelized attention and task saturation. MC was in cold MIC during approach. Had MP been hot MIC, communication would have required less effort, and MP would possibly have informed MR of single engine condition. F-14A NATOPS, ref (c), pg IV-11-23, notes, referring to single eng landings: "the role of the rio is critical in this regime. He should closely monitor a/s, bank angle, altitude, and AOA throughout the approach." MR's lack of situational awareness regarding MA status prevented MR from effectively contributing to crew coordination during a critical single eng emergency. With no engine instrumentation in the R/C, RIO must rely on ICS comm from pilot to be made aware of single eng condition. Based on above analysis, AMB concludes MP failed to communicate eng status to MR due to task saturation, channelized attention and external distraction, resulting in lack of effective crew coordination.

Who: Aircrew, pilot at controls.

What: Aircrew, failure of aircrew coordination, failed to communicate.

Why: Performance, failure of attention, cognitive saturation.

Why: Performance, failure of attention, channelized attention.

Why: Performance, failure of attention, distraction external.

G. Aircrew factor - MR failed to back up mp. rejected. MR maintained flight parameters COMM to MP throughout landing pattern regarding A/S, altitude and position. MR communicated status abeam, at the ninety, the forty five and the start. MR's last comm to MP occurred on final approach approx ten seconds prior to ejection, "We're ten kts slow, let's get some power on the jet." Whether in response to MR or in normal course of flying the approach, MP added power. The critical flight parameter MP exceeded during single eng waveoff was AOA. Since MR was unaware MA was single eng, normal approach A/S, not AOA, was MR's primary scan item. Although MR made no additional COMM after ten knots slow call, it is the AMB's opinion that further A/S calls alone would not have influenced MP to reduce AOA. MP had selected AB, had input right stick and rudder to maintain wings level and counter left YAW >from asymmetric thrust. MP allowed pitch attitude and AOA to slowly increase throughout the waveoff. MR perceived MA was under control and sensed ma would fly away safely. LSO's maintained a continuous series of imperative calls during last seven seconds of MF. AMB believes MP would not have heard or responded to additional information from MR during this time. MR had avia selected on tid. Had MR known ma was single eng, MR could have monitored and communicated critical AOA information to MP, possibly leading to successful

recovery, or opportunity for wings level ejection. Lack of R/C engine instrumentation, or COMM from mp regarding single eng condition prevented MR >from providing proper backup.

H. Aircrew factor - MP failed to respond to LSO calls.

Rejected. MR states LSO waveoff and power calls were received. MP complied in a timely fashion. MP added power on MA prior to waveoff. MP selected AB almost simultaneously with three rapid ``waveoff'' calls and before first ``power'' call. MR did not hear ``raise your gear'' calls transmitted only two seconds prior to aircraft stall and departure. No evidence indicates MP attempted to retract landing gear. Landing gear require approx 9-15 seconds to retract, thus drag reduction would not have time to take effect.

I. Aircrew factor - MP failed to make timely decision to eject. accepted.

mp was distracted externally, and fixated on determining engine and aircraft status while countering YAW and roll from asymmetric thrust. MP instrument scan broke down and MP failed to recognize in extremis situation. mp was task saturated, delaying ejection decision. command ejection was initiated by MR when ma departed controlled flight. Rapid left roll off at low altitude combined with delay between R/C and F/C ejection sequence and left lateral trajectory of MP ejection seat resulted in mp ejection occurring out of envelope. Based on above analysis, amb concludes mp failed to make a timely decision to eject due to external distraction, channelized attention and cognitive saturation.

Who: Aircrew, pilot at controls

Wwhat: Aircrew, failed to make timely decision.

Why: Performance, failure of attention, distraction external.

Why: Performance, failure of attention, channelized attention.

Why: Performance, failure of attention, cognitive saturation.

J. Aircrew factor - MR failed to make timely decision to eject. Rejected.

MR was unaware of single eng condition, though MR knew something was wrong with MA. MR states ejection criteria was based on altitude and sink rate.

MR felt ma flight path had stabilized and was going to fly away. MR was evaluating altitude in reference to CV when MA departed controlled flight and rapidly rolled left. MR initiated ejection immediately upon departure from controlled flight coincident with CLSO ``eject'' comm. MR did not hear ``eject'' COMM from CLSO. In the opinion of the AMB, no information was available to compel MR to initiate ejection any sooner.

K. Material factor - malfunction of primary flight controls rendered MA uncontrollable. Rejected. EI of MA flight control and HYD systems failed to reveal any preimpact failures. Horizontal tail authority mechanism was intact and in unrestricted position. Wing sweep, flaps, slats, and landing gear were in proper landing configuration. EI further shows primary flight controls to be operating normally.

L. Material factor - during single eng waveoff, right eng failed to produce adequate thrust to recover MA. Rejected. There were no performance related discrepancies found on right eng during EI. Right eng was in AB during waveoff attempt.

Right eng MFC was properly trimmed and right eng was operating in zone five AB at impact. F-14 NATOPS (ref C), P V-15-1 states, ``single-engine ... waveoff may be accomplished safely up to the gross weight limits for two engine operation.''

M. Material factor - left eng AICS ramp system failure, caused left eng comp stall in critical flight regime. Rejected. EI of left eng AICS components reveal inlet ramp actuators and inlet ramps were intact and fully stowed in the proper position.

N. material factor - left eng sustained catastrophic failure in critical flight regime. Rejected. EI reveals no evidence of fod damage to leading edge of inlet guide vanes or to low speed turbine. Both low speed and high speed compressor and turbine sections were intact with no evidence of internal failure. Left main eng bearings were examined with no pre- impact discrepancies observed. The left eng was found to be fully capable of

producing normal power at impact.

O. Material factor - faulty left eng MFC caused eng comp stall/failure in critical flight regime. Rejected. EI of left eng MFC indicated MFC was properly trimmed. MFC exhibited no evidence of physical deterioration of internal working components.

P. material factor - MA fuel system malfunction caused left eng flame-out in critical flight regime. Rejected. Fuel was not contaminated with other than salt water, due to long ocean immersion. Both engines were receiving fuel at impact. The left fuel shutoff valve was confirmed open, and the left fuel feed system showed no evidence of preimpact failure. MR states mp reported fuel state during approach and did not indicate any discrepancies.

Q. Material factor - left engine MCB system stuck in bleeds closed position, reducing eng stall margin. Accepted. EI revealed that as received, the fixed position of the directional linear control valve assembly of the MCB system was in the bleeds closed position. The components of the directional linear control valve assembly were found to be caked with a dark powder-like debris. Debris was consistent with normal wear. Normal position for the MCB during landing approach (landing gear down and throttle set at less than military) is open, to allow greater engine stall margin. A stuck closed assembly results in decreased stall margin of up to 26 percent. Based on above analysis, AMB concludes although not sufficient alone to stall the eng, this malfunction, combined with reduced throttle setting and sideslip, contributed to left eng comp stall. component: directional control linear bleed

Valve assembly

Mode: Stuck in bleeds closed position

Agent: wear debris.

R. Material factor - MA experienced radio COM failure. Rejected. MC heard and responded to radio transmissions throughout MF. Last radio transmission >from ma was MR ball call inside forty-five. MR states LSO waveoff and power calls were received.

S. Material factor - MA experienced ICS failure. Rejected. MR and mp communicated normally throughout MF. MP verbally acknowledged ICS call at ninety.

T. Material factor - MA experienced PITOT static/AOA system failure (A/S, altimeter, VSI, AOA, or approach indexers.) Rejected. MA had outstanding MAF indicating R/C A/S was three kts slower than F/C. This discrepancy falls within acceptable limits. Comparison of MR and CLSO statements verify ma pattern altitude, attitude and A/S to be within normal parameters from abeam to forty five.

U. Material factor - MP ejection system failed to operate properly.

Rejected. MP ejection seat gun fired and achieved normal rocket burn approx 0.4 seconds after MR seat, indicating normal command ejection. MP seat ejected with MA in rapid left roll, approx 110 deg left AOB, 55 feet AGL.

Outside Martin Baker MK GRU-7A safe envelope. MP seat impacted water prior to seatman separation, at approx 235 FPS. MP's ejection system worked as designed until water impact damage interrupted normal operation. Impact damage prevented release of MP survival kit lugs.

V. Supervisory factor - FRS failed to provide adequate single eng waveoff training. Rejected. FRS syllabus includes SSE waveoff training during FCLP's. Though MP's day-by-day FRS FCLP gradesheets are no longer available, AMB is confident MP received SSE waveoff training in preparation for both Apr 94 and Jul 94 CQ attempts.

W. Supervisory factor - MS failed to provide single eng waveoff training.

Accepted in Aug 94, MP flew one practice emergency FCLP period in MS prior to TSTA III at-sea period. FLT included SSE touch and go landings but no SSE waveoffs. MP flew no practice emergency FCLP's in oct 94 prior to MF. MPIS CQ simulator in Oct 94 included single eng approach but no single eng waveoff. MF scenario of eng failure in approach turn, followed by waveoff,

requires a high level of situational awareness, proper instrument scan (including AOA), and proper application of FLT controls to fly away safely.

Lack of recent single eng waveoff training reduced MP's proficiency in this critical FLT regime, leading to poor situational awareness and improper procedures. MS may have felt this training unnecessary due to MP's previous FRS training. Additionally, lack of any documented F-14A landing pattern eng comp stalls negated justification for this specific training. Based on above analysis, AMB concludes ms failed to provide single eng waveoff training due to complacency and unforeseeable problem.

Who: Supervisory, squadron, commanding officer.

What: Supervisory, failed to provide training.

Why: Failure of attention, complacency

Why: Decision error, problem not foreseeable.

X. Supervisory factor - FRS failed to disqualify MP for substandard performance. Rejected. MP successfully completed all phases of FRS training and met all qualifying standards. MP disqualified during first CQ attempt.

Between Jun 92 to Sep 94 25 percent of CAT I pilots disqualified during initial CQ attempt. All qualified on subsequent attempts. MP qualified during second CQ attempt and was ranked number three of seven CAT I pilots in landing grades. FRS LSO stated mp was slightly above average and that MP ``should perform well in the fleet.''

Y. Supervisory factor - MS failed to provide MP adequate training in preparation for CQ. Rejected. MP flew eight FCLP periods and eighty-seven graded passes in two weeks prior to MF, more than any other MS pilot. MP's last FCLP flight occurred day prior to MF. MP additionally completed two simulators instructed by ms LSO within two weeks of MF. MS presented MP with five CV/CQ procedures lectures during same period. MP had sufficient ground and airborne training for CQ mission.

Z. Supervisory factor - MS failed to properly manage MC pairing. Rejected.

MP was best of five MS nugget pilots in landing grades during pervious at-sea period. MP had 1024 hours flight time prior to F-14, and a solid reputation. MS was not concerned with MP's overall performance. MR was cruise experienced, and a designated NATOPS instructor. MS considered performance, personality, ability, and experience level when assigning crew pairing.

AA. Facilities factor - CVW LSO's failed to initiate timely waveoff.

Rejected. Because of MP's lack of experience in case I pattern, and in combination with an approach that was out of standards, BLSO initiated early waveoff.

AB. Facilities factor - LSO's failed to use proper LSO terminology after waveoff. Rejected. LSO comm after ``roger ball'' included ``waveoff,'', ``power,'', ``level your wings and climb,'', ``raise your gear,'', and ``eject.''. MP selected ab prior to first ``power'' call. ``Level your wings and climb'' was cut out by CLSO echoing ``waveoff,'', and was not heard by MR. ``raise your gear,'', though not a standard LSO NATOPS call, was appropriate at the time. U.S. Navy LSO school analysis supports LSO COMM was proper and timely.

AC. Maintenance factor - MS maintenance control released down aircraft safe for flight. Rejected. No outstanding MAF in MA maintenance records constituted a downing discrepancy. R/C A/S discrepancy was within allowable criteria for flight. Left eng AB time to stage, though long at five seconds, was commensurate with normal wear and age of engine and within acceptable limits for flight. Maintenance personnel statements and review of records show MA was safe for flight and properly prepared for CV landings.

(end part two)

(continued)

12. Conclusions

A. Mishap narrative: MC flew as wingman during case II recovery for CQ refresher. After normal break and landing pattern entry, MP commenced approach turn. Computed wings level on speed was 139 KIAS. MR noticed aircraft decelerating during approach turn from approx ten kts fast abeam to eight kts fast at the ninety to ten kts slow during final approach. MP flew WUOSX, 42 to 45 deg AOB. CLSO and BLSO observed MA exhibit noticeable left YAW, which was perceived as MP applying left rudder to arrest overshoot. MP reduced power to maintain on speed while rolling wings level. Additionally, MCB system on left engine was stuck in bleeds closed position due to wear debris. These factors combined to cause a left eng comp stall. During postmishap recollection, MR remembered hearing an almost imperceptible "pop," similar to a "popcorn stall," prior to ma crossing ship's wake. During final approach MR transmitted on ICS, "we're ten knots slow, let's get some power on the jet." MP did not respond verbally, but did add power. There was no further ICS comm by MC during remainder of MF. As MA rolled wings level at start, black smoke trail appeared from right eng only, indicating left eng malfunction. MP did not inform MR of eng malfunction. BLSO initiated waveoff verbally and visually for WUOSX. Black smoke trail >from right eng ceased, indicating right eng staging to a/b. CLSO echoed "waveoff" twice, cutting out BLSO "level your wings and climb." BLSO made one "power" call, two "raise your gear" calls and a second "power" call. Throughout waveoff, left YAW and rod persisted. MP had applied right stick and rudder to counter asymmetric thrust. MR did not observe any eng stall warning lights. MP lost situational awareness, failed to scan AOA, allowed pitch attitude to slowly increase and exceeded maximum controllable AOA of 20 units. At approximately flight deck level, MA stalled, departed controlled flight, and rolled rapidly left. CLSO called "eject, eject" as MR initiated command ejection. MR and MP ejection seats both departed MA. MR achieved seat-man separation and main parachute deployment. MP seat fired outside safe ejection envelope, impacted water prior to seat-man separation, damaging seat and interrupting seat sequence. The causal factors of this mishap and injury are a result of overcontrol, external distraction, cognitive saturation, channelized attention, wear debris, complacency and problem not foreseeable.

B. Causal factors of the mishap:

- (1) The narrative cause factors of this mishap are Determined to be:
 - (A) Aircrew factor - MP attempt to salvage overshooting approach led to reduced eng stall margin, contributing to left eng comp stall. RAC II.
 - (B) Aircrew factor - MP failed to execute proper single eng waveoff procedures. RAC II.
 - (C) Aircrew factor - MP failed to inform MR of single eng emergency. RAC II.
 - (D) material factor - Left engine directional control valve stuck in bleeds closed position.

RAC V.

- (E) Supervisory factor - MS failed to provide single eng waveoff training.

RAC V.

(C) Causal factors causing other damage or injury:

- (1) The narrative cause factors of other damage or injury are determined to be:

- (A) Aircrew factor - MP failed to make timely decision to eject. RAC I.

13. Recommendations.

A. Causal factors of the mishap:

- (1) For COMNAVAIRSYSCOM:

(A) Direct one time fleet-wide inspection of F-14A, TF-30 engine mid compression bleed system to include proper operation of directional control linear bleed valve (solenoid) assembly.

(B) review previous recommendations for a newly designed directional control linear bleed valve asSEmblY, particularly the 1993 pratt and whitney component improvement program action item chit design to alleviate wear.

(C) incorporate high-power trim box tests of tf-30 engines between 750 hr hot

section inspections, at 250 hrs and 500 hrs, to determine available thrust, stall margin and proper operation of MCB system.

(2) For COMFITWINGPAC, COMFITWINGLANT:

(A) Add single eng landing configuration to annual OOC trainer syllabus.

(3) For F-14A model manager, VF-101:

(A) Add ``single engine failure, landing configuration'' procedures to F-14A NATOPS manual (ref C), Chapter 14. Procedures should include warning emphasizing importance of AOA during waveoff.

(B) During instructor/replacement act and act instructor designator syllabus, increase emphasis on proper inter-cockpit communication.

(C) Add single engine failure/waveoff in landing pattern to FAM/CQ phase simulator training. F-14A NATOPS manual (ref C), p. IV-16-2.

(4) For commanding officer, VF-213:

(A) Reevaluate criteria for selection of ICS hot MIC mode. Change SOP to verbal acknowledgment of all ICS comms in critical FLT regimes.

(B) During annual act, reemphasize need for proper inter-cockpit communication.

(C) Conduct simulated single engine waveoff practice during FCLP training.

(D) Conduct single engine waveoff practice in CQ simulator training.

B. Causal factors of other damage or injury:

(1) For F-14A model manager, VF-101:

(A) Incorporate and conduct ejection scenarios in FAM/CQ phase simulator training.

(B) Add roll-angle ejection envelope charts to F-14A

(END MIR)

QUOTA-MEISTER JOHN DALTON, [secretary of the Navy](#), is starting to feel the heat for his prevarications about his race and gender policy, which has already led to the death of female aviator.

The death last October of Lt. Kara Hultgreen in an F-14 crash was blamed by Dalton on engine failure. From newspaper reports based on naval documents, it now appears that Lt. Hultgreen was killed by Dalton's quota policy, which allowed her to remain airborne after she had failed performance tests that would have washed a male out of flight school. The Navy has tried to cover up its different gender standards by insisting that pilot error did not cause Hultgreen's tragic crash. To help make this case, male pilots selected to replicate Hultgreen's crash in a ground simulator were ordered not to follow the mandatory procedures for averting a crash in situations comparable to the one that resulted in Lt. Hultgreen's death. According to information obtained by Robert J. Caldwell of the San Diego Union, the simulator tests were rigged and the results were used by Navy spokesmen to absolve the late Lt. Hultgreen of pilot error.

Elaine Donnelly is president of the Center for Military Readiness and a former member of the 1992 Presidential Commission on Women in the Armed Forces. Shortly after the Navy started dissembling about the fatal crash, Lt. Hultgreen's training records and performance reviews were leaked to Donnelly, who also obtained internal Navy

investigative documents cataloguing a series of pilot errors culminating in the crash.

After verifying that the information was authentic, Donnelly issued a special report "Double Standards in Naval Aviation." She shows that Hultgreen was whisked through fl school despite failing grades and a record of serious problems, apparently because she needed to meet a female quota. Donnelly's report contains about 100 pages of photocopies of internal Navy documents that cast doubt on Navy Secretary Dalton's account of Hultgreen's death. The report also chronicles a pattern of disinformation th the Navy has put out about Hultgreen's crash, disinformation that is continuing today.

Dalton's latest inanity is a quota policy that he says will commission new officers "i percentage approximately equal to the racial makeup of the American populace. That translates to about 12 percent blacks, 12 percent Hispanics and 5 percent Asian Americans.

Military services, discontented by open discrimination against white males, cannot serve the country well. To reverse these disturbing trends, the new Republican Congre should wash Navy Secretary Dalton out of service.

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