

COULD THIS HAVE BEEN YOU?

Summary of 1954 Sailplane Accidents

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One of the points that stands out in any listing of sailplane accidents is that there is always an explanation for each accident. It may be poor planning, inattention, lack of a safe landing pattern, no preflight inspection of the equipment, or any one of many other faults. Safe flight in a sailplane requires the pilot to pay attention to four basic considerations; (1) His abilities and experience as a pilot as well as his physical condition, (2) The airworthiness of the sailplane, (3) The condition of the launching equipment and (4) The weather. Item Number (4) very often shows up weaknesses in item number (1). Place the following accidents in one of the four categories and see whether or not you have ever come close to the same situation. Perhaps you have been lucky so far.

1. Pratt-Read. The ship was hurriedly assembled by several people, with the pilot taking responsibility for the front end and the passenger the rear end, with the elevator horn to be hooked up by a person who had never seen a glider before. The elevator bolt was installed through the horn only, not the fitting, then was safetied. No one checked the work. The pilot failed to move the controls for a manual check after assembly. The line starter saw the safety and *assumed* that everything was all right. Winch take-off from the top of the cliff appeared normal but after release at 275', the ship immediately stalled. The second stall produced a dive out speed of 100 MPH past the edge of the cliff and the third stall ended in a tail slide loop with a 130 MPH dive out speed 100 feet above the water. The pilot then used spoilers to damp out the stalls; when he hit the water he was in a 10 degree dive at 70 MPH. The Pratt-Read was extensively damaged and only shoulder harness saved the pilot and passenger from more than bruises.

Cause: Lack of an elementary overall preflight inspection and lack of an elementary control movement check by the pilot prior to takeoff.

2. TG-3A. Private pilot — 85 hours power time, 60 glider flights, took off solo on auto tow and released normally at about 800 feet. He circled once inside the field boundaries, approached the downwind end of the field at 90° to the runway and at a minimum speed and crossed the centerline of the runway with only 150 feet of altitude. He then chose to attempt a steep 270° turn to the left for landing instead of a simple 90° right turn. After 90° of the left turn had been completed, the ship stalled and spun in, striking the ground left wing first. The TG-3A was demolished and the pilot received a severely shattered right ankle and concussion. Shoulder harness prevented more serious injury.

Cause: He failed to fly a proper landing pattern. The pilot had been driving the tow car for two hours and a heavy concentration of carbon monoxide in the car had dulled his judgment to the point where he could not think clearly. The carbon monoxide condition in the car was later verified by CAA conducted tests.

3. TG-3A. A private pilot with very little recent experience took off with a passenger to fly a ridge downwind of the airport. After a flight of approximately 1½ hours, the pilot attempted to return to the airport against a 35 MPH wind and, when he saw he could not make the field, chose another, closer field. He decided at the last moment that he was not going to make this one either and tried a downwind 180° turn and landing from an altitude of about 75 feet. The left wing tip caught in a fence and the ship cartwheeled horizontally. The left wing was demolished and the fuselage buckled. Neistudent or instructor was injured.

Cause: The pilot failed to judge correctly his reduced ground speed; he also failed to pick a field downwind of his position when he still had enough altitude left to fly a proper pattern.

4. TG-2. The pilot-instructor, 70

hours glider, 200 hours power, flying from the rear seat with a student in the front, took off on airplane tow from an airport located on a beach on the side of a ridge. Just after passing the field boundary at an altitude of 75-100 feet, the tow rope broke. There was no safe place to land ahead or to either side, so the instructor started a 180° turn to the right. Parked airplanes prevented a full 180° so the TG-2 was set down in a small cleared area and a ground loop developed when the left wing touched the ground. The aft fuselage was buckled due to side loads. Neither pilot or passenger was injured.

Cause: Failure to check thoroughly the towing equipment.

5. L-K. The pilot took off with airplane tow for a flight to the tiedown area after having served as meet dispatcher for about 5 hours. He was fatigued and his usual cautiousness, which normally took the form of landing the flat-top at well over 50 MPH, led him to land this time at a speed of about 70 MPH. He did not get lined up properly with the runway and thus was led to a last-minute, flat, rudder turn. As a result, the left wing struck an 8" high runway marker light. The right wing then dug into the ground and the ship cartwheeled down the runway, coming to rest with the front of the fuselage badly buckled and both wings broken. The pilot escaped, because of shoulder harness, with only a scratch on his ear.

Cause: Flying when fatigued, over-cautiousness resulting in too high a landing speed and a poor pattern which forced the pilot to attempt a turn at an extremely low altitude.

6. I-19. A student pilot with 22 hours and 81 flights over flat country only, took off by winch tow from the beach at the foot of, and in the lee of, a bluff. The wind was from the bluff thus creating strong local downdrafts. He released at 600 feet and, after a 270° turn away from the bluff, found himself at 250', decided he was too

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