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OXC 5361

Copy 1 of 4

7 AUG 1963

MEMORANDUM FOR: Assistant Director, OSA

SUBJECT: Comments on A-12 Accident Report

1. After a thorough review of the Aircraft Accident Report pertaining to the crash of A-12, S/N 123, on 24 May 1963, I non-concur with the report in the following areas:

a. The history of flight prefacing the report is adequate up to a point, but it does not completely tell the story as to what actually happened to put the aircraft in the position the pilot found himself after completing the turn he started at Wendover. Based on information taken from various sections of the accident report and in an effort to make the History of Flight more meaningful, I propose that a paragraph 9 be added to this section with a more detailed account of the sequence of events that led to the stall and spin (See attachment I). Two graphics with supporting information on this paragraph have been developed: Attachment 2, Flight Profile, and Attachment 3, Airspeed/Thrust Requirements Chart.

b. I do not concur with the Findings and Recommendations in several places. The major area of disagreement is in the primary cause which I consider to be pilot error for failure to take corrective action in a deteriorating airspeed situation and for operating the aircraft in clouds on a VFR local clearance. The blockage of the total pressure port would then become a secondary cause. Concurring or non-concurring remarks as a reviewing commander are submitted in attachment 4. Action of this type would be in keeping with the format and reporting requirements of Para 20, AFR 127-4.

c. The Operations Group in their section of the report make the statement that the pilot was qualified in this aircraft. To support this statement, the report should, but does not contain:

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- (1) A copy of his last standardization ride.
- (2) A copy of his formal checkout in the A-12.
- (3) A copy of completion certificate on A-12 ground school.
- (4) A copy of completion of some form of an emergency procedures examination.

d. The Aerodynamics Section of this report does not come up with any definite conclusions, findings or recommendations. Since the aerodynamics analysis of flight conditions just prior to and during the sequence of events which led to the stall is the key to what actually happened in this particular accident, specific conclusions, findings and recommendations by the aerodynamics group are essential to the validity of the report.

e. We feel there is a certain amount of supervisory error evident in the areas of (1) quality and manner of conducting briefings for A-12 missions; (2) chase aircraft SOP's, i. e., chase aircraft procedures, chase pilot responsibilities, etc.; and (3) in that the pilot failed to take corrective action in a low airspeed/unusual attitude situation, and failed to recognize the danger signal in the illumination of the surface limiter light. It is possible that emergency procedures and flight characteristics may not have received adequate attention in prior A-12 training. The need for an A-12 simulator makes itself quite evident and a recommendation to that effect has been included in Attachment 4.

f. The Accident Board had no recommendation to make on contributing causes b. and c. (b. established the fact that the MACH Trim subsystem added further nose up trim, increased angle of attack and rate of airspeed bleed off; c. established fact that the pilot failed to take corrective action.) Both these findings are extremely relative in this particular accident and I feel that the Board's failure to come up with a recommendation for these two causes tends to "water down" the case. The minimum acceptable recommendation for both these items would have been that all A-12 pilots be rebriefed in the accident with emphasis on the flight control systems and flight characteristics of the aircraft. I note in his comments on the accident report, [] has recognized this point and has taken the corrective action to brief his pilots on both these points.

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25X1A 2. As a result of the Headquarters review and analysis of the accident report, recommend that a letter be forwarded to Commander, pointing out the inconsistencies and inadequacies in the report. This letter should require additional information and/or corrective action in accordance with the Headquarters review of the accident report.

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Deputy for Field Activities, OSA

Attachments - 4
As noted above

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This document contains information referring to Project **OXCART**

Put in file on 26 Aug 63 with charge that no further action will be taken by Proj.

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Concern handling of Bel

Control course & course have been averted if pilot performing better

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