



DEBRIEFING

Flight Safety is Everybody's Business

ENGINE DAMPER WEIGHTS

(27 May 03 - Occurrence # 112206)

While inspecting the engine damper weight assembly, rear support and bushings of a Sea King helicopter, a technician noticed that the damper weights were installed backwards and too far aft on the engine support tube. Investigation into maintenance records revealed that the engine support tube was installed on 11 Feb 03. Interviews with the involved technicians were conducted during which the CFTO Damper Weight installation procedures were reviewed. It was determined that technician inattention to published maintenance procedures was causal. Furthermore, the independent check was not carried out even though its requirement was indicated on the CF349.

Debriefing. In this case the technicians involved did not adhere to details outlined in the applicable CFTO and the Crew supervisor failed to recognize the requirement for an independent check. Errors attributable to personnel inattention will never disappear from our often complex, routine, yet time-critical operations. Preventative measures generally involve a briefing to personnel (as was the case here) or a comment on a maintenance or aircrew notice board. So why does "inattention" continue to occur? Without trying to sound repetitive, this incident re-iterates how critical our "routine" responsibilities are: do you take the extra time to confirm that all the procedures have been carried out? If required, do you accept a slight delay to your deadline to ensure that what you are doing is done thoroughly and correctly? As a supervisor, do you maintain the right balance between micro-management and adequate supervision? At the end of the day, remember that the safe culture we work so hard to establish during peacetime and training at home will be our foundation for successful operations when we come to the big crunch.

FE MONKEY BELT

(9 May 03 - Occurrence #111689)

While preparing to do a boat hoist sequence, the SAR Tech Lead noticed the Flight Engineer's (FE) monkey tail hook-up was pip pinned to the aircraft instead of being bolted. The FE monkey tail was re-attached to a bolted 'D-ring' and another FE



safety check was carried out. This aircraft had arrived from another unit and, for a period of three months, several maintenance and flight engineer checks were carried out before this problem was noticed. During the Pre ship/ water hoisting check, the flight engineer asked one of the SAR Techs to carry out a safety check. The SAR Tech noticed that the flight engineer's safety attachment D-Ring was the wrong kind and that it was only secured with a pip pin. The flight engineer moved his monkey tail attachment to another secured D-Ring, and then the SAR Tech once again confirmed the safety check as being secured and complete. Upon landing, the D-Ring attachment pip pin was replaced with proper hardware and the aircraft was signed out serviceable.

Debriefing. Although on the surface this may appear to be an innocuous minor discrepancy, this occurrence could just as easily resulted in a fatality had the pip pin been inadvertently kicked by a crewmember while manoeuvring in the cabin. How did the incorrect hardware get installed on the aircraft? How did the anomaly go unnoticed during multiple inspections by technicians and FEs? It is a well-documented fact that mundane tasks, tasks that are repeated countless times over the span of a career are often the tasks that are either missed or performed improperly. Verification of life support equipment by either the technicians maintaining the component or by the aircrew utilizing the equipment must be carefully executed each and every time. The life you save could be your own!