



# DEBRIEFING

**Flight Safety is Everybody's Business**

## **TECHNICIAN STRUCK BY CANOPY**

**(03 Oct 03 - Occurrence #114002)**

This mission was a two-plane instructional, formation sortie with the first aircraft flown solo. The pilot of the lead aircraft arrived at his plane and requested the ground crew of the number two aircraft to solo (secure) his rear cockpit for solo flight while the number two pilot completed his Pre-External Check. The lead aircraft ground crew had not yet arrived and securing the rear seat is considered a servicing responsibility.

The lead pilot entered the front cockpit after his Pre-External Check, strapped in and commenced the Pre-Start Check. The pilot's assigned ground crew had arrived by this time. While the technician securing the rear cockpit was still bent over the canopy rail, the pilot inadvertently closed the canopy on the technician's back. The technician was pinned between canopy and canopy rail. The pilot heard the technician moan, realized what had occurred and opened the canopy. The technician finished the rear seat tie down and went back to start of the number two aircraft. Following the start, he went to the hospital. The subsequent doctors examination revealed that the technician had sustained nerve and muscle tissue damage to his middle back.



Cockpit (Solo Flight) Check could only be completed after the servicing crew had finished and prior to his strap-in. As aircraft captains, we are responsible for the operations in and around our aircraft. It is incumbent on us to know what is happening and where personnel are in relation to our aircraft!

## **AIRCRAFT CONFLICT**

**(09 Oct 03 - Occurrence #113786)**

This is a story about what can happen when dissimilar aircraft, which are carrying out different missions, operate in close proximity to each other. The story begins at an East Coast airport, where a CC130 on a SAR trainer is orbiting VFR overhead the aerodrome at 4000 feet ASL. There is a CH146 Griffon (with a Student pilot and an Instructor pilot onboard) inbound to conduct an approach and overshoot, and several Cessna 172s are either in the circuit or transiting the area, along with a CH149. Finally, the ATC personnel are working out of a secondary facility with reduced visibility and no Radar Situation Display.

The Terminal controller had given the CH146 overshoot instructions following completion of its IFR approach. The Instructor pilot in the Griffon acknowledged this transmission, but the Student did not hear it as he was concentrating on his flying duties. Terminal then told the CH146 crew to switch to Tower for the remainder of its approach. However, the Tower controller did not inform the Terminal controller, during the landline conversation reference the Griffon overshoot overhead the field, that a CC130 had already



This incident could have resulted in more serious injuries. As aircrew, this incident reinforces the requirement to follow the Check List. The pilot's Rear

been cleared for a live drop of two SAR Techs and to not allow the Griffon to fly over the aerodrome.

The Tower controller, although told by the Terminal controller that the Griffon was flying overhead the aerodrome, expected the Griffon to be further north and therefore no conflict with the CC130 dropping SAR Techs. This would have worked, had it not been for a navigational error made by the Griffon crew, which was due to the missed clearance. By the time the error was corrected, the Griffon was on a direct intercept course with the CC130. The Herc crew took evasive action and cleared the Griffon by 300'.



There were other contributing factors to this near-accident. One was the ongoing construction in the primary control tower, which necessitated a move to the alternate tower facility, which does not have a Radar Situation Display. Another was that the Student pilot was concentrating on flying the appropriate route of flight and failed to hear the ATC-issued vector which his Instructor acknowledged. Finally, the Instructor pilot, in an effort to allow the Student pilot to regain his situational awareness and to benefit from the training, allowed the student to continue towards the aerodrome and the CC130 vice the issued vector, which generated the potential for a more serious incident.

Don't let a good training opportunity interfere with the safe operation of your aircraft, and always keep your ears, as well as your eyes, wide open. Fly Safe!

## HAZARD REPORT

Personnel at all levels must maintain vigilance for potential hazards within the work place. This could take the form of unsafe work habits, environmental conflicts, or management direction. The Hazard Reporting Form can be used to alert the Flight Safety System to potential problem areas. Remember, it can be sent anonymously and can be directed to any member of the Flight Safety team of your choice. While having a point of contact is always preferable, an anonymous report is much better than no report at all. Remember Flight Safety is everybody's business!

<span style="font-size: 1.2em; font-weight: bold; margin-left: 10px;">HAZARD REPORT</span>	
<p>A safety <b>HAZARD</b> is any condition that has the potential to cause injury or damage. <b>YOU</b> can prevent accidents by reporting hazards. Please take a moment to complete this form. Pass the completed form to your FSO/NCM as promptly as possible so that hazardous conditions may be addressed <b>BEFORE</b> they cause an occurrence. The report may be submitted anonymously.</p>	
<p>Hazard Description: The hazard I observed is</p>   <p style="text-align: right; font-size: 0.7em;">Use flip side of form if required</p>	
<p><b>HAZARD SEVERITY:</b> Select the consequence that best describes this hazard:</p> <p><input type="checkbox"/> 1. <b>CATASTROPHIC:</b> Death, system loss or severe environmental damage.</p> <p><input type="checkbox"/> 2. <b>CRITICAL:</b> Major (Red or Yellow) injury, or occupational illness or major system/environmental damage.</p> <p><input type="checkbox"/> 3. <b>SIGNIFICANT:</b> Minor (Green) injury, or occupational illness, minor system or environmental damage.</p> <p><input type="checkbox"/> 4. <b>NEGLIGIBLE:</b> Less than minor injury, or occupational illness, less than minor system damage or less than minor environmental damage.</p>	
<p><b>PROBABILITY:</b> Estimate the likelihood of this hazard occurring:</p> <p><input type="checkbox"/> A. <b>FREQUENT:</b> Likely to occur frequently.</p> <p><input type="checkbox"/> B. <b>PROBABLE:</b> Will occur several times.</p> <p><input type="checkbox"/> C. <b>OCCASIONAL:</b> Likely to occur sometime.</p> <p><input type="checkbox"/> D. <b>REMOTE:</b> Unlikely, may occur.</p> <p><input type="checkbox"/> E. <b>IMPROBABLE:</b> Very unlikely, assume that it may not occur.</p>	
<p>Your name, rank, unit &amp; phone number: (for feedback purpose only)</p>	<p>(may be anonymous)</p>
<p><b>Suggested solution:</b></p>  	
<p><b>Action taken:</b></p>  	

## FEEDBACK TO DFS

Write to: [dfs.dsv@forces.gc.ca](mailto:dfs.dsv@forces.gc.ca)