



DEBRIEFING

Flight Safety is Everybody's Business

ATC UNSAFE IFR CLEARANCE

You copied the clearance but was it safe? This recent incident demonstrates the intricacies of some procedures that are not always transparent to the pilot.

This light aircraft was departing an airport in one terminal area (A) and almost immediately after take off transiting into another area (B). The pilot requested his IFR clearance via phone from A, prior to taking off. A, in turn, requested via phone the IFR clearance from B and passed it on to the pilot at the airport.

The Minimum Enroute Altitude (MEA) for the flight-planned route was initially 7800 ASL, thereafter dropping to 5500. The B IFR clearance passed to A and subsequently, the pilot, was for 5000 ASL! While A was passing this clearance to the pilot, they were simultaneously on the phone getting a revised clearance from B to pass to the pilot. The new altitude clearance was for 3000 feet or 4800 feet below MEA or 1000 feet below the "maintain 4000 or as assigned" departure instructions for the airport. The correct altitude was only passed to the pilot after he was airborne and talking to A. Got you thinking?

Before you put this in the black and white category, you should know the pilot flight planned the wrong altitude. He initially got the 5000ASL he requested. Why the revision to 3000 ASL? The 3000-foot is an authorized altitude for a local regional carrier but not for this type of aircraft. It is also the MEA closer to the destination airport. Why did two terminals not pick up on the discrepancy sooner? What was the pilot thinking? Did the fact that it was VMC have an impact? Bottom line: the pilot is always responsible and is the last factor in flying safely. Be aware! Be very aware!

INADVERTENT DISCHARGE OF FIRE BOTTLE (16 Dec 03 - Occurrence #114439)

The next story describes what can happen when you mistakenly select the wrong switch. While unfeathering the right hand propeller, the technician in charge inadvertently discharged the right hand fire bottle into the engine. It happened during the final stages of a periodic inspection on a CC115 Buffalo. It was not possible to install the propeller afterbodies on the right hand engine due to the blade angle of the propeller. To solve the problem, the incident techni-

cian entered the aircraft, sat in the right hand seat, and proceeded to pull the right hand feather button with his left hand. The technician was looking out the right window towards the engine when his hand slipped off the underside of the feather button and inadvertently grabbed the fire handle, causing fire bottle to discharge.



Following the discharge, all aircraft power was turned off, the aircraft was vacated, and the hangar doors were opened to dissipate any discharged gas. The three technicians who were located under the right hand nacelle at the time of the discharge were sent to the local hospital and subsequently released. The Wing Environmental Officer was informed and the right hand engine fire bottle was replaced.

The Cause Factor assigned for this incident was Personnel Inattention in that the technician's attention was not focused on the proper switch selection. As a preventative measure, the maintenance personnel were briefed on the importance of maintaining situational awareness at all when operating any aircraft controls.

This is not the first time that an incorrect switch selection has led to an incident. A CC130 crewmember once shut down the wrong engine, a result of not confirming that the correct engine condition lever was selected. More recently, a crewmember on a CH146 beeped down the engines rather than paying out the hoist cable as intended. This led to the pilot carrying out an autorotation, and resulted in major damage to the airframe. We can all learn from this. Look before you leap!