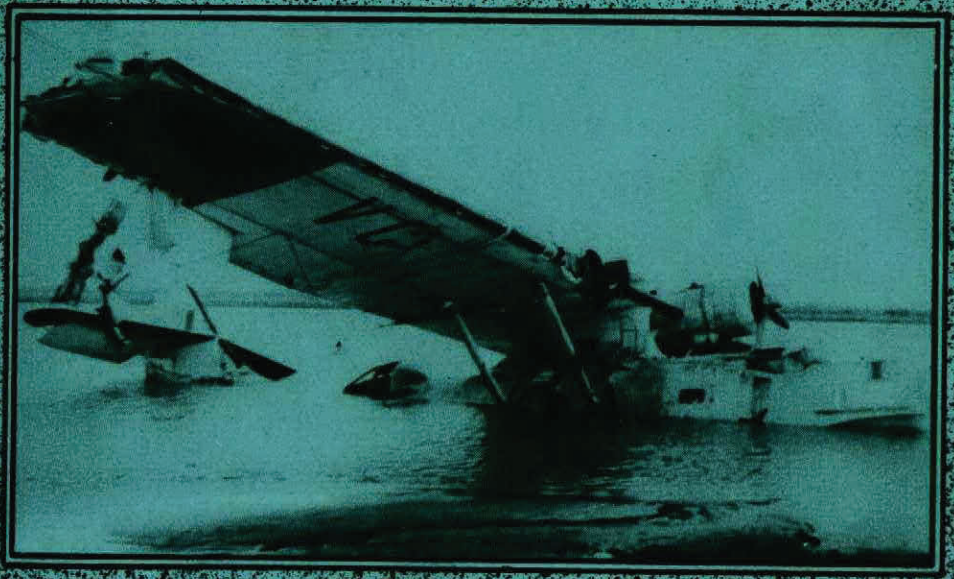
RESTRICTED

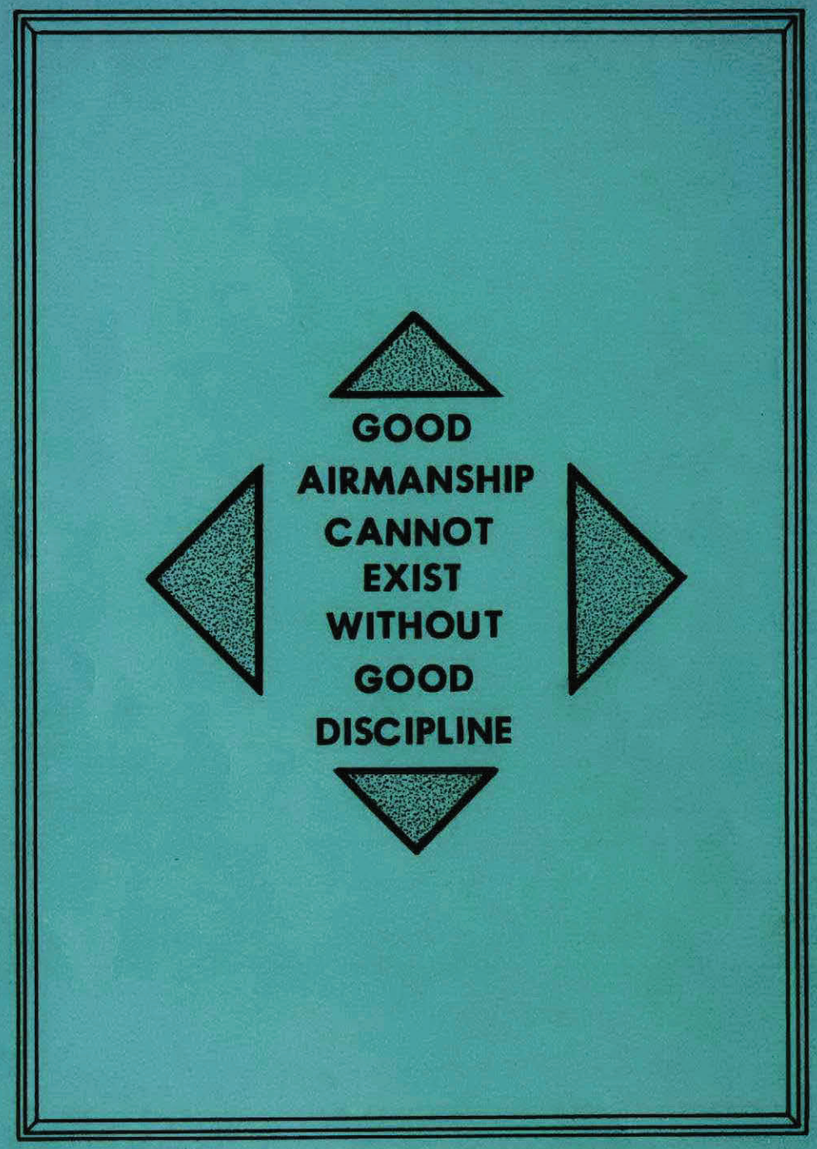
CRASH COMMENT

ACCIDENT PREVENTION

JANUARY FEBRUARY MARCH 1950



ISSUED BY
ACCIDENT INVESTIGATION BRANCH
R.C.A.F. HEADQUARTERS OTTAWA ONT



Editorial

OVER THE HUMP?

Our scientific friends tell us that the "hump" is the peak resistance in the performance curve for a given flying boat hull or seaplane float, which must be overcome by the power of the engine. Those of you who have operated seaplanes, flying boats, or speed boats for that matter, know that once this "hump" resistance is passed, the going is easier on the airframe and engine, to say nothing of the pilot. At this stage, control becomes easier and the pilot gets the feeling that the "ship" is co-operating. Indirectly the task of the man who maintains the aircraft or speed boat, and that of the man who supplies the spares, is made easier because the engine ceases to strain and the frame is relieved of wave shock, etc.

From where we sit in AIB, we have that "certain feeling" about the RCAF generally. By comparison with the same seasons of previous years, our accident rate has been gradually decreasing for some time. All branches in the air and on the ground, by working together, are winning the "conflict of crashes". Although it's a good show and your efforts are greatly appreciated, we're not quite "over the hump". There still is that high precentage of accidents attributable to pilot error, which can and must be reduced.

Let us return to our analogy, the flying boat. We're on the step. A change in attitude, speed or power at this time may force us to the wrong side of the "hump" and we may have to go back for another try. The inefficiencies associated with taxiing back for another take-off run are apparent. Similarly, to retrace our steps in accident prevention would cost us lives, money and operational hours, not to mention the wasted time in maintenance, overhaul and supply.

There is an accident prevention organization within the RCAF whose responsibility it is to get us over the "hump". This organization can only succeed in its task by the combined effort and co-operation of all personnel in every department.

HOW ABOUT YOU?

Welcome to "Wave Off"

We read the new RCN Publication "Wave Off" from cover to cover and we congratulate the Navy on the production of a very high standard periodical.

We take this opportunity of welcoming "Wave Off". We wish the magazine and the publisher good luck and continued success.

SPECIAL MENTION

THE BARN DOOR

As we go to press each quarter we invariably get the feeling that we're closing the barn door after the horse has escaped, so we thought that we might recall some of the accidents which happened last summer just in case someone else's experience would be of help to you during this year's operations.

THE RIGHT TIMING

We had a couple of ground loops in Expeditors when trained pilots were being checked out with a built-in crosswind and no dual brakes. AMC is having the brakes installed at the most expedient time - during overhaul - so, in the meantime we suggest that the checks be done on "into-wind" days if possible.

HEELS OVER HEAD

Like so many "simple" types of aircraft, the Norseman has some deceptive characteristics. It is easy to fly as long as you have the proper introduction to the brakes, which have a habit of being pressed by the pilot's toe before landing and then over it goes. Then there's the eternal debate on where the tail wheel should be at touchdown - high, low or on the ground. An experienced Norseman pilot will demonstrate - ask him to show you before you go solo.

THE OLD SPINNING WHEEL

We had one or two cases of inadvertent spins after which we were unable to get the pilot's statement. A check-out on aerobatics and spin recovery in the Harvard might be an idea at this time.

REFRIGERATION

The usual number of Harvard engine failures occurred when the

ground temperature was steaming. Many of us, including the pilots concerned, would not believe that a drop in boost could mean ice in the carburettor. After all wasn't it Summertime?

THAT GIRDLE

Then there's the usual number of accidents where we suspect that if the seat belt or harness had been securely fastened, lives would have been saved. In any event, if you're in doubt, we suggest you discuss the benefits of seat belts with the four occupants of an Expeditor which flipped over on it's back during a landing one night. If the seat belts had not been done up, we might have been marching slow time again and, without a doubt we certainly would have been sending flowers to the hospital.

HABITS

We had the usual crop of undercarriage collapses due to unclean cockpit habits. There were also two or three cases of premature up-selection which damaged the retracting mechanism and caused subsequent collapse on landing. To the unit check pilot or training officer we commend a bit of tightening up or, perhaps you as an individual will anticipate this requirement. You are a professional pilot not an amateur. Are your cockpit habits clean?

STILL WATERS RUN DEEP?

The Eskimo will tell you that dark water is O.K. but don't take this as a general rule, particularly when you are flying Canso aircraft. During grey days most water, particularly north of the Circle, appears dark. Conversely, during sunny days, it has that clear, transparent appearance which makes you think that every sandbar is just under the surface. What is more, our geological friends tell us that ice will move rock shoals and that the channels at river mouths are altered annually. So if you landed in that spot last year don't assume that careful examination is not necessary this year.

If you ask any of the experienced pilots what to do about landing in strange waters they will give you this sort of briefing, but will end up by saying that they won't guarantee anything. They all suggest, however, that you take your time. Look the situation over carefully. Select your landing path, your probable take-off runs, your beach, mark them by prominent features, then go in and land or find yourself another landing area. Remember that the wind may not be as strong or in the same direction to-morrow, so make sure you have enough length for a glassy water take-off.

Last year we had a few cases of damaged hulls due, possibly, to

too much haste. Sometimes it takes as much as an hour to beach an aircraft. Sometimes it's wiser to sail in rather than to use power. When in doubt get the old lead-line out and put the wheels down. Always use a crewman in the bow.

It's all very well for us to sit here and theorize, but we know enough about operating conditions to understand that, regardless of care which you take, landing in strange places has hazards which even you may not be able to anticipate. We ask you to use extreme caution.

Of course, there's the one where the crew struck a dock, we don't remember the specific details, but it could have been a combination of wave, tide, wind or current. Then there's the buoyancy aspect of salt water as compared to fresh water. Don't depend on the "Water-line method" of loading. Sea operations are different. You get off sooner. You draw less water. These variables exist in different proportions during every operation of a flying boat. They require your undivided attention.

We have not mentioned the many successful landings and take-offs carried out by crews in unknown waters, but we can assure you that many a successful operation has been completed and that those crews are still with us. We suggest that you avail yourself of the opportunity to talk these problems over with them before you go down North.

STABILITY

For some time now we have been stressing the importance of the CG position and the knowledge of performance of your aircraft when the CG of the load is not in the ideal location. There is one accident to a Dakota flying on one engine, reported in this issue, where the crewman piled equipment near the door and then all concerned wondered why the single engine performance was not up to scratch. There are other instances where pilots are amazed at the excessive change in trim with change in power and also where considerable control column movement is required for boat take-offs. We commend to these people the use of the pertinent loading stick and we suggest to those of you who have been fortunate enough not to have had this experience, that you use the proper loading calculations henceforth.

Don't use the same basic index for every aircraft on your strength, it may not be the correct one. We know of two apparently identical Dakota aircraft which have 680 pounds difference in basic weight.

If by chance your aircraft have not been weighed recently, all the necessary facilities are available at Repair Depots and at Station Rockcliffe.

Use them.

TOO TIGHT

Our frequent visits to Units give us an opportunity to assess the work being done by the maintenance crews and we can say with assurance that we have, and are developing, some real technicians in the full sense of the word. In most instances we have found enthusiasm, diligence and pride in getting the job done properly.

On the other hand we can quote the odd instance where a "so-called technician" bent a certain part of a Vampire aircraft to make it fit. Then there's the case where a 7/16" bolt was installed in a 1/2" hole and those concerned wondered why the undercarriage collapsed. There's another one where some unknown "mechanic" pulled the locking nut up with something like a two foot wrench, then wondered why the bolt failed and was forced out of position when the aircraft landed.

Let us not pull them up too tight, let us not leave them too loose, let us have the correct tension. If it doesn't fit get a new one, or at least consult your NCO or Engineering Officer. If in doubt, ask. You will save yourself a lot of work and you may save a life.

BULK HEAD VALVE

A recent Dakota accident brought to light the fact that numerous pilots were unaware of the correct procedure for using the hand pump shut-off valve, commonly referred to as the "bulk head valve".

Apparently instructions given during the late war implied that this valve had to be open before emergency procedures could be used. This is incorrect, as in flight the bulk head valve always remains closed and, in the event of a pressure failure, the hydraulic units are actuated directly by the hand pump.

The attention of all Dakota pilots is drawn to EO 05-35A-1 (CAP 36 Para 225 (b)) and EO 05-35A-2, which outline the proper use of the hand pump shut-off valve.

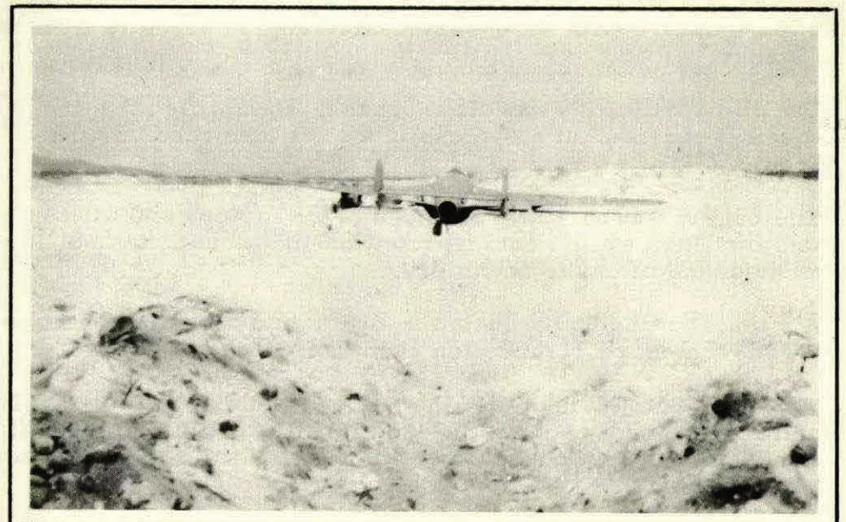
* * * * * * *

Comments or suggestions regarding the contents of this publication are welcomed and should be addressed to:

CAS,
AFHQ,
Ottawa, Ont,
Att'n: AIB.

ACCIDENT RESUMÉ

VAMPIRE



* NO. 1 -- TAKE/OFF DIFFICULTY

The above Vampire, during take-off, exhibited a tendency to roll to the left immediately on becoming airborne. The pilot re-applied the wheels to the runway, increased speed and resumed normal take-off procedure. When airborne the aircraft again began a roll to the left. Thereupon the pilot closed the high pressure cock and landed straight ahead wheels down. The aircraft ran off the end of the runway into deep snow.

Damage was estimated at ten thousand dollars.

The cause of the accident was not definitely proven. However, small patches of ice, which could have had an effect on the aerodynamic qualities of the aircraft, were found on the upper surface of the port wing. The evidence suggested that the pilot caused the aircraft to leave the runway at too low an airspeed and that the peculiar behaviour of the wing was due to a succession of stalls.

* NO. 2 -- FLAME OUT

During an authorized armament exercise, comprising ranging, tracking and mild evasive action, the pilot of one of the Vampires participating states: "At about 10,000 ft. (with throttle setting 9000 - 9500 rpm) I eased the nose forward losing about 2000 ft. and gaining airspeed. Then I pulled the nose up into a steep climb gaining approx. 4000 ft. As the airspeed dropped to the vicinity of 200 mph I eased the stick forward and experienced the sensation of engine noise dying down." At this point, according to the pilot in the accompanying aircraft, the Vampire with the unserviceable engine began to trail thick white smoke.

The pilot fortunately was close to base. He notified the tower and subsequently carried out a successful wheels up forced landing on the aerodrome.

The engine was partially stripped at the factory and all components and ancillary equipment inspected and functionally tested. There was no evidence of unserviceability.

Air tests are being conducted in order to determine the effect of throttle movement on combustion at high altitudes.

We have been advised that the "G" pot holds about two gallons. Its endurance depends upon altitude and throttle setting, so even if the EO says 20 seconds we suggest you reduce this time to the minimum for the operation.

* NO. 3 -- CANOPIES

There still is the odd case of canopy structural failure brought to our attention. This one occurred during a routine navigation exercise at 25,000 ft. The pilot was flying straight and level when, without warning, the canopy perspex suddenly disintegrated. The pilot was momentarily confused by the sudden change of pressure and dirt getting into his eyes. However on realizing what had happened he turned on the emergency oxygen supply, opened the dive brakes and was able to return to base without difficulty.

Research on canopy tops continues.

* NO. 4 -- SLIPSTREAM CAN BE DANGEROUS

The Vampire pilot was No. 2 to land. Either being the eager type, or not fully aware of the dangers involved in running into slipstream, he approached too closely behind the lead aircraft. His port wing, encountering No. 1's slipstream, dropped and struck a snow bank near the end of the runway.

The cause was assessed as error in judgment and the pilot was grounded for the remainder of the Exercise.

* NO. 5 -- TAKE-OFF - VISION OBSCURED

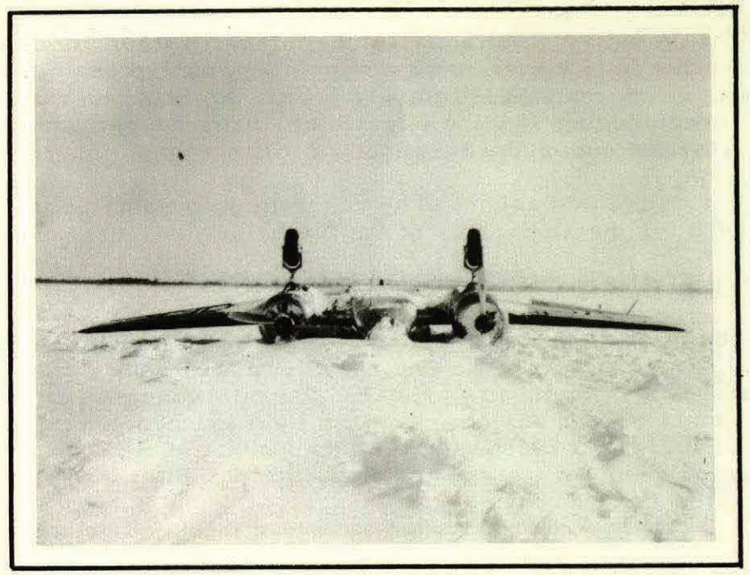
The pilot taxied into position, lowered 30° of flap and prepared for a formation take-off. Part way down the runway he noticed that the aircraft was edging to starboard. The pilot unsuccessfully attempted to make minor adjustments with light touches of brake. He then applied full rudder which had no effect because of the slow speed. The starboard wheel hit a snowbank on the side of the runway causing the aircraft to ground loop.

Damage was estimated at twelve thousand dollars.

The cause of the accident was attributed to a combination of inexperience and negligence on the part of the pilot. A contributing factor was one to two inches of light snow on the runway which reduced visibility.

The pilot was grounded for the remainder of the Operation.

EXPEDITOR



* NO. 6 -- QUESTIONABLE JUDGEMENT

Pilot error, which accounts for over 65% of our accidents, was responsible for the Expeditor's unceremonious position as pictured above. Luckily no one was injured.

The captain, an experienced instrument pilot, attempted a combination visual (head out window) and instrument take-off in moderate snow conditions. He failed to maintain directional control and allowed the aircraft to run off the edge of the runway into snow in which it subsequently overturned.

It is interesting to note that, according to the weather sequences, six minutes before the attempted take-off of the Expeditor the visibility was below the limits laid down for that particular airport. Although the visibility may have momentarily increased, to at or above limits, the pilot's judgement in commencing a take-off in such conditions is certainly open to censure. His method was equally questionable.

* NO. 7 -- CROSS-WIND LANDING

The Expeditor in this instance came to rest in almost the iden-

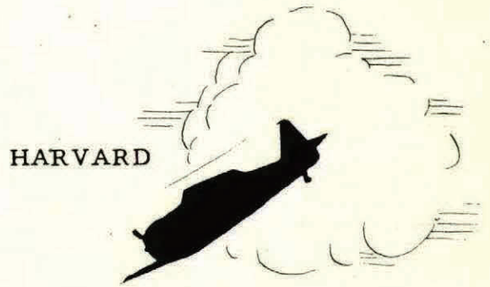
tical position of the one in the preceding case.

The captain was landing in a severe cross-wind and failed to keep the aircraft straight. This resulted in the Expeditor running off the runway into deep snow and overturning. Again fortunately, no one was injured.

At least it can be said that the Expeditor has a high safety factor after being overturned.

* NO. 8 -- UNDERSHOOT

The problem of short runways and nil wind presents a psychological problem as well as a physical hazard. This was aptly demonstrated recently when the captain of a Ventura allowed a pilot under instruction to undershoot to the extent that the aircraft undercarriage struck the top of a wire fence bordering the perimeter of the aerodrome. Fortunately only minor damage resulted and the aircraft was landed without further incident.



* NO. 9 -- SPEED ARTIST

The student pilot attempted to turn his aircraft in a confined space while travelling at excessive speed and while not maintaining an adequate lookout. Result - The starboard wing tip struck a control tender.

We sincerely hope that a reproof and a contribution towards partial compensation for damages incurred has impressed upon this pilot the Air Force attitude regarding preventable taxying accidents.

* NO. 10 -- COLLISION

The pilot, on returning to the hangar area after a night flight, taxied his aircraft into a parked Harvard. The resultant damage totalled a little over three thousand dollars. The investigation revealed that:

(a) the navigation lights of the parked Harvard were out;

(b) there were no flares or obstruction lights beside the parked aircraft;

(c) flying control did not advise the pilot of the location of the parked aircraft.

The remedy in this case is self-evident.

* NO. 11 -- GROUND LOOP

Following a normal approach the Harvard touched down in the three point attitude then started a swing to the left. The captain states he applied full opposite rudder and subsequent right brake but was unable to prevent the aircraft from travelling off the runway and nosing up in the snow.

There were no contributing factors to this example of pilot error.

The pilot was subsequently reproved.

* NO. 12 -- ENGINES DO GET COLD

After practising aerobatics at 6000 ft. the pilot decided to carry out a simulated forced landing from 5000 ft. The pilot states that, although he cleared the engine at approximately every 500 ft., when he opened the throttle at 100 ft. for the overshoot the engine caught only momentarily then quit.

After his third attempt at opening and closing throttle the engine caught but by this time the aircraft was so low the left wing struck the top branches of a tree.

Fortunately the pilot was able to fly back to base. The port wing had to be replaced.

The Unit's assessment of the cause was "Inadequate precaution on the part of the pilot under existing weather conditions."

* NO. 13 -- THE REAL THING

The student was practising simulated forced landings from 3000 feet. He cleared the engine periodically down to 1300 feet, but for some unknown reason from there on he became so engrossed in getting into the field that he forgot to pay any more attention to the engine.

The Harvard came to rest on it's belly, in the middle of a field, fourteen miles from the parent aerodrome.

* NO. 14 -- INSTRUMENT TAKE-OFF

The exercise was intended to be a normal simulated instrument take-off but ended with the Harvard sitting wheels up a 100 yards beyond the end of the runway.

Reports relate that during the initial stages of take-off the student allowed a swing to develop, resulting in the aircraft running into wet snow alongside the runway. The instructor applied full power, but the Harvard failed to become completely airborne because of drag caused by the wheels running in the snow and a reduction in lift caused by slush adhering to the leading edges and under surfaces of the mainplanes. Thereupon the instructor, deciding there was insufficient area left for take-off, closed the throttle and selected wheels up.

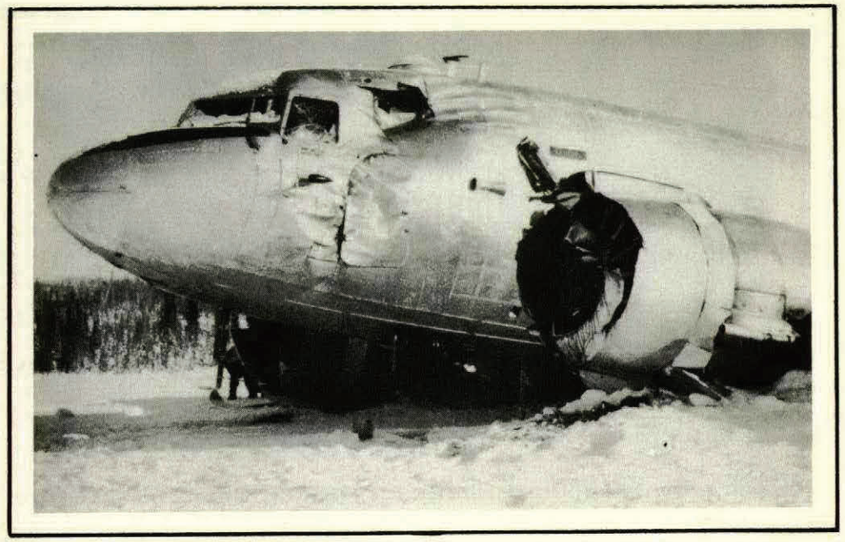
The primary cause of the accident was attributed to the instructor failing to take over control soon enough after a swing developed.

* NO. 15 -- ICE AND SLUSH

The following case is a typical example of what can happen when the temperature increases just enough to start melting the ice and snow on the runway:

The instructor was demonstrating precautionary landings on the aerodrome on a day when temperature conditions were ideal for the freezing of water and slush to the undersurface of the aircraft. Although the pilot was aware of the existing conditions and knew ice was building up on his aircraft, he did not increase his speed sufficiently on approach. On rounding out the aircraft stalled and the port wing struck the ground.

Fortunately the damage was not serious.



* NO. 16 -- SKI FLYING - CHECK OUTS ARE IMPORTANT.

The captain of the Dakota commenced what was intended to be a normal ski take-off from a lake covered with twelve to fourteen inches of snow.

As the aircraft gathered speed the main skis left the snow surface first, leaving the tail ski still on the surface of the lake. At this point, according to the captain, the control column came fully back and the aircraft shot into the air. The captain then called on the co-pilot for assistance. The co-pilot helped to push the control column forward and cranked on nose heavy trim while the captain reduced power "to prevent a full loop." The speed at take-off was between 50-60 knots and according to the navigator fell off to zero prior to impact.

The aircraft after becoming airborne travelled a distance of 250 yds. and then completely stalled. On impact the skis and wheels were driven up into the wheel wells and both propellers and reduction gear housings parted company with the aircraft. Extensive damage was

also done to the fuselage and mainplanes.

An examination of the aircraft failed to show any indication of ice on the control surfaces or on the underside of the fuselage. Further investigation disclosed no evidence to indicate structural failure or non-removal of control locks.

The reason for the accident was assessed as "error in judgment on the part of the pilot." Contributing factors were:

(a) The pilot had not received sufficient dual instruction to make him proficient on ski equipped aircraft.

(b) The pilot had no previous experience on loose snow.

(c) The pilot did not utilize all the room available for take-off.

(d) The aircraft was taken off in a three point attitude at or near the point of stall.

(e) Improper use of elevator trim during take-off.

This accident happened to an experienced wheel Dakota pilot and the obvious lesson to be learned is that personnel converting from wheel to ski equipped aircraft must be thoroughly indoctrinated by fully competent check-out pilots. It would also perhaps be quite appropriate to mention here that ski aircraft cannot be trimmed off a loose snow surface in the same manner as a wheel aircraft can be trimmed off a runway.

As the accompanying photograph would indicate the aircraft has joined the "write-off fraternity" and come summer will make like a submarine.

* NO. 17 -- CROSS CHECKING IS VITAL

It would appear, from viewing the pictures in this issue of Crash Comment, that Dakotas have a peculiar habit of coming to rest the hard way. However such is not quite the case and in this instance poor airmanship was a vital factor in bringing the aircraft's life to an abrupt end. Briefly, here is what happened:

Shortly after take-off the captain noticed the stbd. oil pressure gauge needle fluctuate between 40-100 lbs. and finally settle on 40 lbs. The stbd. oil and cylinder head temperatures remained within normal operating limits. As oil venting from the stbd. engine had been noted during previous flights of this aircraft, the captain assumed that venting was again occurring and discontinued the climb. As the wind at ground level was light the pilots decided to land in the opposite direction to their take-off. A 180° turn was executed, wheels lowered, three-quarters flap set and a descent of 1000 feet per minute was initiated. A fairly heavy snow shower was in progress and an early morning glare hampered visibility.

At 800 feet visual contact with the ground was established, but as the aircraft was directly over the airport landing at this stage was considered impossible. Overshoot action was taken and flaps raised

to 1/4 position with a resultant loss in altitude. At this point the oil pressure fell off to zero and the stbd. propeller was feathered. Again the oil and cylinder head temperatures remained within normal operating limits.

The aircraft lost altitude steadily and crashed about two miles from the aerodrome. Fortunately no one was killed.

Subsequent inspection of the stbd. motor and it's accessories showed no lack of oil and there were no signs of oil on the external surface of the aircraft. However a stoppage was found in the autosyn oil pressure transmitter line. This stoppage was considered responsible for the oil pressure gauge reading inaccurately.

The following are excerpts from the approved findings of the Court of Inquiry appointed to investigate this accident:

(a) The Captain feathered the stbd. engine without closely checking his oil and cylinder head temperatures.

(b) Incorrect overshoot procedure was used.

(c) Incorrect emergency method was used for raising the u/c.

(d) The Captain failed to check the load sheet.

(e) The aircraft was overloaded some 390 pounds.

(f) The Captain was not aware of proper operating oil temperatures.

(g) Incorrect rudder trim was applied.

The reason why the Dakota would not maintain height on one engine was never definitely ascertained. However the Court of Inquiry reported a very low standard of airmanship on the part of the pilots.

The Captain of the Dakota has been reduced to co-pilot status.

* NO. 18 -- NOSE WHEEL LOCK

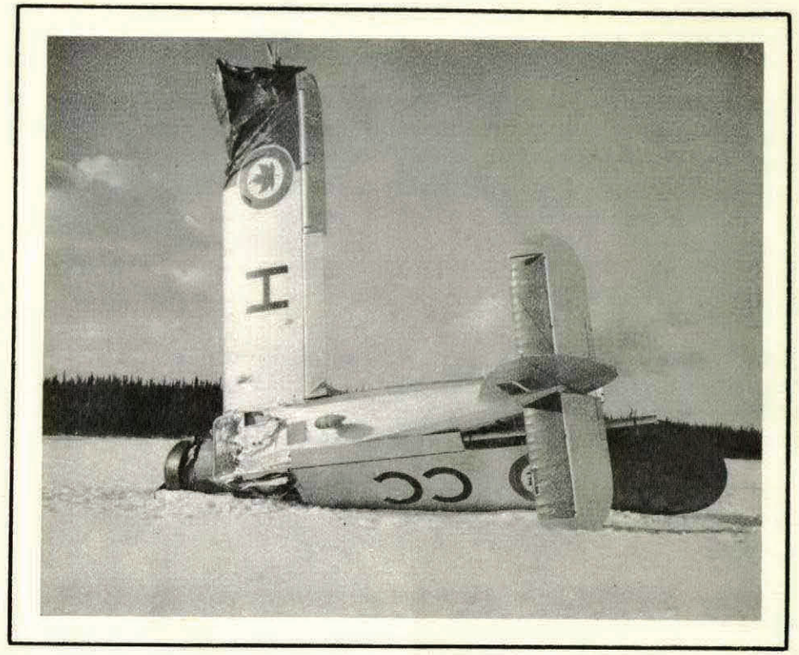
During take-off run a severe vibration developed. The pilot closed the throttles and cut the switches. A visual check of the nose wheel assembly revealed that the tow pin cap was unscrewed and that the nose wheel was at an angle of approximately 60°.

The tow pin was engaged, the tow pin cap secured, and a take-off was completed. The pilot then noticing that the flight instruments were inoperative, returned to the airport.

Further examination revealed structural damage to the airframe of so serious a nature as to result in a "B" category assessment. This damage had been caused by vibration which developed because the towing pin in the nose oleo leg was not engaged, as a result of which the nose wheel was free to castor during the attempted take-off.

The pilot received a reprimand as a result of his negligence.

NORSEMAN



* NO. 19 -- CARTWHEEL

Overcast conditions and a broad expanse of snow set the stage for this "A" category crash.

The pilot in attempting to land misjudged his height and the port ski struck the snow before round-out had been completed. The port oleo leg broke causing the aircraft to swerve to the left. The ensuing skid caused the starboard ski to dig in and resulted in the aircraft swinging violently to starboard and then rolling over on its port side.

The cause of this accident was "pilot error" because the captain did not realize the loss of depth perception under certain light and snow conditions.

As mentioned earlier in this issue conversion to ski flying requires thorough and competent instruction.

* NO. 20 -- PRACTICE MAKES PERFECT

Visibility $1\frac{1}{2}$ - 1 3/4 miles and ceiling 800 - 1000 feet, combined with darkness, almost led to tragic consequences for this Lancaster and crew.

The captain arrived at the range station, completed a let down on the aerodrome served by the range, and obtained permission for special VFR to his destination approximately ten miles distant.

After having made three unsuccessful attempts to align his aircraft on the runway in use at his destination, he returned to the radio range station in order to attempt a let down on the airport served by the range. A standard instrument approach was completed but the subsequent runway procedure again ended in failure. The tower personnel informed the pilot that they would fire off red flares in order to assist him in locating the aerodrome.

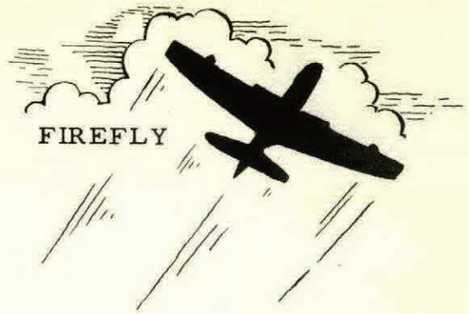
The pilot circled the range station in an effort to catch sight of the flares. In so doing he neglected his altimeter and the aircraft struck a tree. The resultant damage rendered the airspeed indicator useless.

A landing was finally effected with the aircraft running into snow off the end of the runway. Luckily no further damage occurred.

The aircraft did not proceed to an alternate because the crewman had advised the captain that insufficient fuel was available. Subsequent inspection disclosed almost four hundred gallons of fuel in the rear bomb bay tank. An unserviceable fuel gauge, which was unserviceable at time of take-off, failed to indicate this amount during flight.

The pilot had completed the IFS course two months previous to this time, but his log book indicated that in the intervening period he had carried out no standard instrument approaches.

The captain was reduced to co-pilot status pending investigation and a check into his flying abilities



* NO. 21 -- UNDERCARRIAGE RETRACTION

Certain pilots, for some unknown reason, cannot resist the temptation to retract the undercarriage immediately they consider the aircraft is airborne. They do not seem to realize that correct judgement at this stage is crucial, and that the slightest error can have serious results.

The pilot in this instance had a beautiful curl in the propellor tips to show for his effort of touching back on the runway after becoming airborne and having retracted the wheels. Incidentally the power plant also had to be removed and returned to the manufacturer for overhaul.

Luck was with the pilot - he was able to complete a circuit and carry out a safe landing.

The pilot was placed on charge and remanded for the taking of a summary of evidence. Disciplinary action is unknown at time of writing.

SUMMER IS HERE AGAIN

.... but remember ....

1. Aircraft Performance (Particularly Jets)

As the air gets hotter:

- more runway is required for take-off.
- rate of climb is less.
- approach speed is greater.
- landing roll is longer.

* Atmospheric pressure is important. Low pressure will further aggravate these conditions.

2. Thunderstorms

Here are a few of their associated dangers:

- hail.
- ice.
- turbulence.
- lightning.
- static.

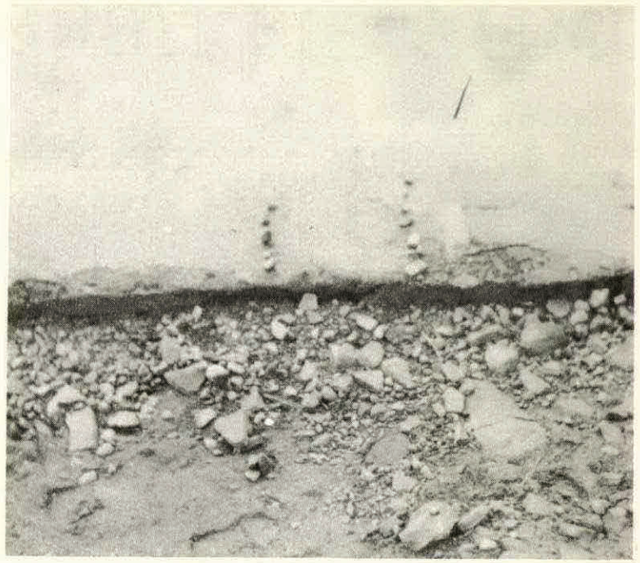
3. Maintenance

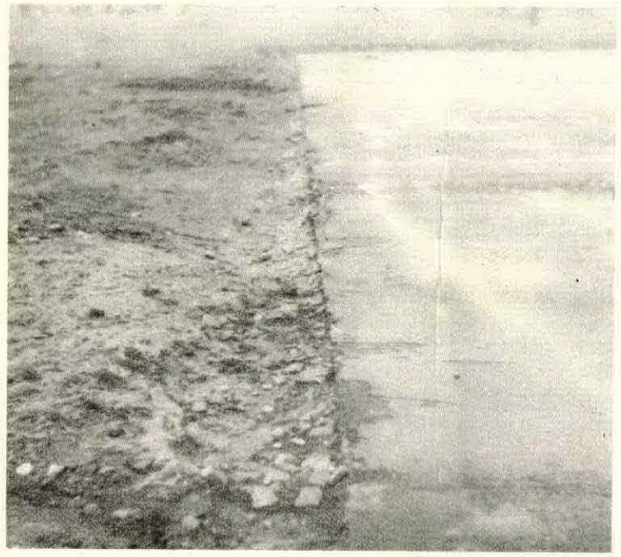
- Longer take-off runs are a temptation for undercarriage pre-selection with consequent structural damage which can only be discovered by rigid inspection.

- Hot weather and long landing runs combine to cause excessive strain and wear on tires. Blow outs are often costly!

RUNWAY SERVICEABILITY

An undershoot here would cost us an aircraft.





TAKE A LOOK

AT

YOUR RUNWAYS

GOOD SHOW

Our "Good Show" for this quarter goes to 4633 LAC R J Wrightson from NWAC.

LAC Wrightson was crewman of a Dakota which crashed shortly after take-off. On being informed by the captain that an emergency landing was imminent, LAC Wrightson moved rapidly to the passenger compartment and assisted all occupants in fastening their safety belts.

His complete disregard for his own safety enabled all passengers to be securely fastened, and his action undoubtedly was responsible for there being no casualties during the ensuing crash landing.

ACCIDENT PREVENTION