For the month of September there were 61 USFS SAFECOMs submitted, this is below the 10 year average of 79. Of the 61 SAFECOMs; 14 were for fixed-wing, 5 for airtankers, 25 for helicopters, 16 for helitankers and 1 N/A.

SAFECOM Statistics

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SAFECOMs by Aircraft Type

- Helitanker: 26%
- Airplane: 23%
- Airtanker: 8%
- Helicopter: 41%
- N/A: 2%

SAFECOMs by Category

- Maintenance: 52%
- Incident: 14%
- Hazard: 24%
- Management: 4%
- Airspace: 6%
SAFECOMS by Category continued

AIRSPACE - There were 4 airspace events reported, consisting of a conflict, intrusion, procedure and a near mid-air. The near mid-air event was avoided by the manager pointing out the encroaching aircraft to the pilot who then took evasive action. Great job by the crew. It can’t be stressed enough how important it is to be watching out for other aircraft, even when there’s a TFR.

HAZARD - Communication issues accounted for nearly half (47%) of the SAFECOMs in this category. The remainder consisted of one or two reports in the following subcategories: Flight Following, Fuel, Passenger Loading/Unloading, Pilot Action, Policy Deviation, and Weather.

INCIDENT - There was not any one issue that stood out in this category. There were a couple of Dragged Loads, Injuries and Precautionary Landings and only one dropped load.

MAINTENANCE - Fifty-two percent of the reports submitted were maintenance related. The most reported were Electrical issues which accounted for 29% (10 reports) and Engine issues at 21% (9 reports).

MANAGEMENT - There were two internal management reports and one external management report.

Have you taken the SAFECOM Survey yet?

Ever feel like you don’t make a difference? Want to really have an effect on aviation safety?

Well, here’s your chance!!!!

The Interagency SAFECOM Working Group developed a quick survey to get feedback from you- the user. In an effort to reach as many folks as possible we have put it on the internet linked from the SAFECOM home page and from the icon below. Please take 5-10 minutes to complete the survey and provide us with your thoughts. The survey will be open from October 1, 2009 to July 31, 2010 to get the widest possible respondent pool. A running total of responses will be posted on the SAFECOM website, and survey results will be distributed shortly after it closes.

A big THANKS to those (nearly 200) that have already taken the survey and given us some great feedback.
These are samplings from the SAFECOM’s submitted for the month of September.

09-0836: On September 23, 2009, a prescribed burn was being conducted. Due to the nature of the vegetation, helitorch was being utilized. The helitorch crew was operating efficiently, the gel mix was the proper consistency and the helitorch unit was performing well. At approximately 1600, while dispensing gel, the helitorch unit was brushed up against the last two feet of a tall fir tree. The helicopter airspeed was just above a hover. The contact with the tree produced no apparent damage; however, the helitorch stopped working and the aircraft returned to torch base. Inspection of the helitorch unit revealed that apparently the contact with the fir tree had misaligned the propane flame outlet and extinguished the propane flame. After adjustment of the propane flame outlet, the helitorch was returned to service and burn operations were continued with no further incident. CORRECTIVE ACTION: Pilot and manager discussed proper flight levels in regards to aerial ignition. Pilot recently had days off. Manager called Regional HOS to discuss situation.

09-0835: While hot-fueling in between bucket cycles, the hose connection between the fuel hose and hose reel broke free on the fuel truck spilling approximately 5-10 gallons of JET-A on the grass. The driver of the fuel truck was able to shut off the fuel flow in a quick manner preventing more fuel from spilling from the fuel truck. The helicopter shut down and was able to get fuel from a different vendor. CORRECTIVE ACTION: The mechanic and fuel truck driver were able to identify that the stainless steel hose clamp failed. They cut off a short piece of hose where the connection was made onto the hose reel, re-attached the hose to the hose reel and replaced the old clamp that failed with a new stainless steel hose clamp. They topped off the helicopter with the new clamp in place and were able to fuel the helicopter without further incident. Forest aviation officer and safety manager were notified. RASM Comments: Proper procedures and appropriate contacts made in this occurrence. Its also appropriate to notify the Resource Advisor for the Incident in an instance such as this one, no matter how small the spill.

09-0834: While supporting the a fire, Helicopter XXXX was on its third and final long line mission. Attached was a daisy chain of two full 72 gal. Blivets and a 12x12 cargo net with full back pack pumps attached at lowest daisy chain. Qualified ground personnel were guiding the helicopter into the same area as the prior two missions, communications were prompt and effective. As the cargo net was lowered to the ground, the pilot stated that a wind shift occurred which caused the aircraft to settle in down flowing air. The pilot then released the load, established forward flight, and communicated with ground personnel. The lowest blivet was approximately five feet off the ground at the time of release. All ground personnel were well clear of the site, and confirmed that a strong wind shift occurred just before the load was released. After communicating with ground personnel, the helicopter returned to the configuration site and informed the helicopter manager of the event. CORRECTIVE ACTION: After talking to Pilot and other Helibase personnel there was a decision made not to do any more missions to the fire until the winds lessen. Prior to the mission, with the helicopter manager and one other helicopter crewmember on board, the pilot performed two slow passes over the sling site in order to accurately judge the current conditions, the conditions were favorable at the time. The Fly Crew assigned to the helicopter reviewed the Interagency Aviation Lessons Learned dated August 22, 2008 on Wind and Terrain Analysis (IALL 08-05), and thoroughly discussed Lines of Demarcation, and the effect it plays on the helicopter’s performance. The Fly Crew also discussed sling site selection, and the use of ridge top as opposed to using down slope locations. The local Forest Aviation Officer was contacted and agreed with the corrective actions taken. HOS: This demonstrates just how quickly the environmental conditions can change ever so slightly and jeopardize a mission. Excellent After Action Review conducted by the Fly Crew following this event.
09-0806: Jumper xx was dispatched to one of the many lightning fires within the area of the fire. Jumper xx entered into the Fire Traffic Area (FTA) without contacting Air attack (AA) on any of the assigned frequencies for the incidents. There were numerous fires in this area within a 5 miles radius. We heard Jump xx contact the ECC at 17:08 to let them know the configuration they had on the aircraft. The ECC informed them to change to the forest net frequency. The forest dispatch had remained in communication with Jump xx on National Flight Following during this time. From that time until 1803, AA was unable to contact them on any frequency. Thru that whole process AA tried numerous times to contact them on all the assigned frequencies. AA finally got a hold of them on air guard. This was after they already had performed and completed jumps and cargo operations. I felt real uncomfortable with this whole situation and all other aircraft that were flying the other incidents within our control also felt and expressed their uncomfortably with the lack of communication with jump xx. The assigned leadplane had also tried numerous times to contact jump xx, while he was lining out airtankers on another fire within the 5 mile radius. Finally around 1759 the lead had made contact and informed Jump xx that we had been trying to get a hold of them, due to airtanker air operations happening in the areas where they were working. We had a total of 3 airtankers, one lead plane, one helicopter, and an air attack working in this area during this incident. During the aircraft operations over the multi fire incident, air attack had positive radio contact with all aircraft working the fires, except Jump xx. The proper procedure was for Jump xx to contact the air attack at 12 mile from the incident according to the Fire Traffic Area procedures. The standard procedure is if contact cannot be made they are to stay out of the area and not enter till they had received clearance to come in the fire area. Jumper xx was not cleared into the FTA to start jump operations on the fire, however they still entered the airspace and started to jump and they performed cargo drops onto the fire located in our airspace and under our control. I made sure that all other aircraft was aware of this situation along with the leadplane. Our main goal at this point was to keep all aircraft away from this area until they were done. During this time we tried numerous times to get a hold of them. I even contacted the ECC before all this situation occurred, that we did not want the Jump ship to perform any operations on the fires until they had their radios on the right frequencies. I wanted them to return to their home unit, and not jump the incident because they were not needed. They made the whole aviation operations within this area very dangerous to deal with and placed all other aircraft assigned in a bad situation. I am not sure why they continued into the fire area and commenced operations knowing that you need to make contact with the assigned air attack. CORRECTIVE ACTION: Submitters Comments: Make sure that all aircraft follow the procedures according to the Fire Traffic Area, prior to entering into any fire. RASM Comments: With this an Interagency and Inter-regional dispatch a number of calls have been made. In talking with one of the supervisors that was on Jump xx, but not on the radio, a number of issues were brought out. First was that they, the jump ship takes full responsibility for the situation in that they had a new spotter to the area on board the aircraft, and he was not aware of this Regions stand practice and need to use an FM Air Tactics Freq. so he was not on the proper freq. Second they have tracked down that it appears that they had a tone on the receive side of the freq. they were using, thereby inadvertently tone protecting themselves from the other radio traffic. Third, the resource order that they received from dispatch did not have any mention of other aircraft or fires in the area, so they did not know an FTA was in effect on their arrival. Lastly they do agree that the appropriate thing that should have been done after not being able to communicate with everyone else is to return to base. That is the take home message here, IF YOU CAN’T COMMUNICATE ON THE ASSIGNED FREQUENCIES THEN YOU NEED TO LEAVE THE OPERATIONS AREA AND LAND UNTIL IT’S FIXED.

09-0771: Helicopter was performing back haul missions. When helicopter returned, the aircraft had two swivels on the hook not allowing the load to spin while in flight. CORRECTIVE ACTION: Good Catch, good response and feedback to personnel on line for future operations. Helibase Manager contacted Air Attack who contacted the helispots to inform all helitack qualified personnel to utilize only one swivel on the hook at a time.
09-0839: Bucket struck trees on successive approaches to the dipsite. One strike was only a gentle brush, but on the next approach the pilot put the bucket on top of a large cedar as he was descending into the dipsite. The bucket hit with considerable momentum, knocking down several large limbs. The pilot then applied power and sprung the bucket free of the tree, and opted for an easier dip site located less than 2 air miles away. The dipsite was in a hole. Located at the base of a 15 foot tall waterfall in a small drainage, and surrounded by steep slopes carpeted with large old growth trees and snags, ingress and egress to the dipsite was difficult, requiring either the snaking of the buckets through small alleys between trees or a straight down descent from directly above the pool. Egress required full power to pull above the trees. This was coupled with very little clearance between both the main and often time’s tail rotors, depending on aircraft and particular approach the pilots took. There was very little margin for error at this dipsite. CORRECTIVE ACTION: Before the bucket strikes were witnessed, the I.C., Safety Officer, Helibase Manager, and the Air Attack for the fire were told of the tight conditions present at the dipsite by dipsite managers (three different people had occasion to manage the site). The helibase manager was informed of the bucket strikes after they occurred. The dipsite managers suggested only allowing vertols to utilize the site, as they had significantly more clearance between the trees and their aircraft, though they too had to snake their buckets in on the approach. The helibase manager agreed, but eventually Air attack approved the site for use by any aircraft, provided it had a 180 foot longline, and allowed the pilots to choose based on their particular comfort level. Several more bucket strikes were witnessed over the course of the next few days, none were much more than a light brush. Local UAO comments: A contributing factor to this event was the separation of the dipsite managers from the helibase and most of the air group. This was due mostly by not having an adequate helibase location on or near the district where fire operations, ground resource and most overhead were. Drive time from helibase to the District Office is approximately 2 hours and then at another 30 minutes up forest roads to the dipsite, making it impractical for the dipsite managers to be located at the helibase. Communication between the dipsite managers and helibase was by phone or by radio rely through the Air Attack. This was proven to be ineffective and identified too late. Another option that could have been explored would be to have the dipsite managers flown to and from the incident helibase and District Office helispot in order to participate in morning briefings and debriefings.

09-0837: After a flight over the fire, the pilot noticed a small amount of oil pooling on the bottom of the left engine’s right cowl flap. After a visual inspection, it was determined that the probable cause of the oil leak was from an internal seal in the engines gear-driven alternator. The aircraft was taken out of operational status and released for maintenance. The determination was verified by company maintenance personnel upon further inspection. CORRECTIVE ACTION: The alternator was replaced with a warranty replacement alternator from the manufacturer. After installation, the aircraft was returned to service by company maintenance personnel. RASM Comments: Good catch by the pilot, highlighting the importance of pre-flight inspections. Proper procedures for maintenance verified and aircraft was returned to contract availability by the AMI.

09-0742: After the last flight for the day while doing a post flight inspection the mechanic found a tail rotor blade that was debonding internally from the honey comb. The mechanics have been doing a very good job of finding mechanical issues before they become big problems. CORRECTIVE ACTION: The tail rotor blade was replaced last night and the crew is in the process of balancing the tail rotor. AMI comments: All procedures were followed with excellent maintenance practices by Contractor and great timely reporting and follow-up by FS Manager. UAO: Good job by the maintenance people and good coordination with the Regional Aviation folks. The right folks got involved and the ship was able to be put back to service in a timely manner. All procedures followed.
**09-0824:** Mission: Longline a blivet to personnel on a fire. Events: We found a landing zone 100 yards from a lake. We shut down to fill up the blivet and configure for longline. The remote hook was attached to one end of the 100` longline and the electrical was plug into the belly of the helicopter. The thought was to wait until the blivet was filled and then do the 1, 2 and 3 checks. When the blivet was filled and ready for flight, the HECM (t) and HMGB forgot the checks and thus forgot to hook the longline to the belly hook. The helicopter flew into position over the blivet with only the electrical plug holding the longline and remote hook. Another HECM attached the remote hook to the blivet and moved out of the way. The HMGB told the pilot the load is hooked and the hitcher is clear. As the pilot started to lift the load, the nine pin disengaged and dropped 100 feet. The mistake was recognized right away by the HMGB that the longline was never hooked to the belly. The pilot landed and shut down. The mistake was discussed with all involved, we did the 1,2,3 checks, hooked the longline and continued the mission successfully.

**09-0823:** Sunset 1923 Civil Twilight 1953 At 1845 call from dispatch: a man in the wilderness with possible broken pelvis. Life Flight helicopter not available for the next four hours. County SAR/EMT and first responder are on their way to the helibase. 1900 Pilot and EMT arrive at helibase and we discussed civil twilight time. Looking at the map, the patient was 25-30 miles north of Helibase. 1920 lifted the HB, while in flight I reminded the pilot if he felt uncomfortable we could turn around. He said he was fine. Dispatch told us where the ambulance would meet us. 1936 landed at the location of the patient and shut down. EMT was told the man was thrown from his horse and the patient said his pain level was 10 out of 10. EMT`s assessment- possible broken top of femur. 1944 I notified dispatch we would be lifting soon and per pilot, he requested the ambulance meet the helicopter at another location. Having never flown at that location and not knowing the hazards, the pilot preferred to land at an alternate site six minutes flight time) beyond the requested site. This location is a well used helispot with no aerial hazards. At 2000 loaded patient into the helicopter (took a lot longer than expected due to the weight of the patient: 275 lbs). 2003 lifted with the patient, 2012 landed and met the ambulance 19 minutes past civil twilight. CORRECTIVE ACTION: Hindsight: Landing at the airport, six minutes further would have been safer. Since it was dark before we landed, the better decision would be to land at the helibase/controlled airport with a lit windsock.

**09-0822:** Upon departure from ATB a heavy airtanker accidentally dropped a small amount of retardant on the runway. ATB staff tried to summon the ARF truck at the ATB to wash the retardant off the runway, but could not raise the ARF on the radio. After a delay, the ARF truck was contacted and cleared by ATC to wash the runway clean. The active runway was closed for approximately 45 minutes with 5 airtanker and 1 lead plane in a holding pattern around the field. The retardant was washed away and the runway re-opened without incident. CORRECTIVE ACTION: Submitters comments: A conversation was had with the ATBM and the ARF personnel to clarify radio notification procedures to ensure a more timely response to a retardant spill RASM Comments: Talking with the submitter of this SAFECOM my concern on what if this had been an accident on the runway instead of spill? If we are paying for this service then we need to make sure there is a common understanding of the expectations and the communications/notifications that will take place. The submitter assured me that those topics had all been addressed and remedied.

**09-0797:** During fueling, after returning from a fire dispatch, I noticed that the left nacelle tank took forty gallons more than the right nacelle tank. The transfer pumps tested normal prior to take off and I retested them again after fueling and they tested normal again. CORRECTIVE ACTION: Talked to maintenance and float system that turns on transfer pump was suspect. It was recommended that pilots watch the amount of fuel in nacelle tanks. All the pilots that fly that aircraft have been notified. AMI comments: Fuel system operating normal at this time. This is an informational Safecom and the A/C will be monitored for future issues with fuel system. Authorized Aircraft Service Center and Contract Company have been notified.
09-0746: During an air attack mission the ship experienced a FADEC fault light. After inspection, the NP sensor wiring harness was found to be frayed and in need of replacement. CORRECTIVE ACTION: The harness was replaced and the ship was placed back in service after a test flight by the RMI. UAO: Looks like all the right people got involved and made the right decisions. AMI comments: All procedures were followed.

09-0816: During a proficiency rappel I had the lat straps on my harness snugged down tight. As I rotated off the skids I felt extreme pressure on my rib cage. I rappelled to the ground and walked away from the aircraft thinking that the pain would cease once I had completed the rappel. The pain persisted and I believe that the discomfort may have resulted in a combination of pulled muscles and/or cracked ribs. CORRECTIVE ACTION: It is hard for me to tell exactly what happened but I wonder if since the harness was tight it caught on the rib cage and actually pulled things out of place as I went inverted. Contacted MTDC to discuss what happened. This does not appear to be the first time this has occurred and MTDC would like to provide follow up. RASM comments: Initial notification with the local unit and RO could have gone better especially with an injury, but getting the information to MTDC on the possible equipment issue is a plus. Although rumors abound of this type of event, this is the only SAFECOM documenting the issue. Being unable to really understand what happened, prevention is tough. Folks should be aware of this event and it should be discussed in training. We need to document in a timely manner through the SAFECOM system if it happens again, so we can get at what is going on.

09-0812: On September 19, 2009 at approximately 1830 hrs, I was assigned as initial attack air attack on a fire. I received a radio call from Division Z, the Division supervisor stated the helicopters had made a low water drop in the area of a handcrew near the heel of the fire. I was advised that a crew member had been injured, and the helicopters needed to give crews more time to clear the intended drop area prior to making water drops. After further conversations it was discovered that a Helitanker had made the water drop in question The water drop had struck a 16`` DBH Cedar Snag and knocked the snag to the ground. As the snag was falling a portion of the snag struck a member of the hand crew causing the injury. CORRECTIVE ACTION: Submitters Comments: I contacted all helicopters over the radio and advised the need for them to allow more time for crews to leave the intended drop area prior to dropping water on the fires edge. Additionally the helicopters were advised to work farther out ahead of the crews while cooling the fire edge. RASM Comments: I went to the incident and met with the Crew Supt. of the crew involved and the Deputy Fire Staff. Information obtained at that time indicated that there was still some confusion as to which aircraft was involved, and even if it was a skycrane or different make and model of helicopter. This was due to the relatively high number of aircraft, 5 Helicopters working in a very small area with quick turn around times. On initial report of this it sounded as if there had not been communication between the aircraft and the ground resources, but it was determined that wasn’t the case. They were talking and giving and taking direction, however on at least this drop there was just an announcement that we are coming in for a drop and within seconds the drop was coming through the canopy. The individual involved attempted to get behind a tree, but was struck on the wrist by a portion of the snag. This obviously had the potential to be much more serious in nature. After de-briefing with the Supt. the Deputy Fire Staff and I went to the Helibase and had the base stand-down and have all of the flight crews and Managers come to the Comm trailer. At that time I discussed with all of the pilots what had occurred and that I wasn’t there to focus on finding out “who” the pilot was, but wanted to make sure that all of the pilots were aware of what had happened and how important it was to make sure that their drop areas were clear of personnel. If the area was not clear or if contact could not be made then they needed to go around and not drop.
09-0782: While in cruise flight back to Helibase after completing a 2 hour cycle of Retardant drops, the “Master Caution” light with the “Inter Trans Oil Press” caution capsule illuminated. The caution capsule light momentary illuminated approx 4-5 times before coming on steady. Immediately the crew landed as soon as possible at an adjacent Elementary School football field. While in decent to the field the crew contacted the Helicopter Coordinator, Air Attack, and a Heli-Tanker to advise of the situation and give location. During the final landing phase, the “Inter Trans Oil Press” caution capsule light extinguished. After landing and shutting down, the crew contacted Maintenance, appropriate personnel of the above situation via cell phone. Maintenance and manager arrived on site shortly thereafter and changed out the “Intermediate Gear Box Pressure Switch”. Aircraft was run-up for operational/leak check which resulted good. Aircraft and crew then returned to Helibase less than 5 nm away. While in the descent to Helibase the “Inter Trans Oil Press” caution capsule momentary illuminated during the descent/shutter phase of flight. Maintenance personnel are looking into further causes. CORRECTIVE ACTION: Submitter Comments: Crew Chief replaced the IGB oil pressure switch, ops check and leak check were good during ground run. On further inspection, Crew chief found Chaffed, Bare wires approx 16 inches away from IGB pressure switch. Wires were repaired and system ops check was done. Aircraft was flown and put back in service by RAMI the next day. RASM and Air Operations notified of incident. Since the beginning of this contract, Aircraft has logged 311 hours of flight time. We are on the side of Safety and strive to make the best decision in the time of an emergency situation. This incident had a good outcome thanks to the flight crew and all the others. RASM Comments: Good decision to land the aircraft immediately rather than try to get back to the helibase. Good notification of this incident through all the appropriate channels.

09-0777: On 9/8/09 at approximately 1630 three helitack personnel were picked up from H-6 by Helicopter pilot and manager. The understanding was to approve H-7 and return to helibase. Upon arrival at H-7 three approaches were attempted, two with doors open for tail rotor clearance check requested by manager. A spot was chosen by pilot and manager. The pilot stated he would be keeping power up while we exited the aircraft. Helitack was instructed by the manager to exit the aircraft and cut a helispot. Upon exit of the aircraft all helitack personnel noticed that 1 to 2 feet of the tips of the skids were on a sloped hillside nose in and the remainder of the skids were approximately 2-3 feet off the ground. The helicopter was unloaded and departed. CORRECTIVE ACTION: Submitters Comments: The Helibase manager was notified of the situation shortly after return to helibase. RASM Comments: These type of landings are not approved, we need to assure that our helispots are in a condition where we can have the skids on the ground and the aircraft at flat pitch. However, in talking with the manager in this case he indicated that there were some extenuating circumstances. The site had been dust abated, but it had been inadequate and when they came in there was quite a bit of dust. The Manager had crew in the back check for tail rotor clearance due to the reduced visibility and he saw the skid on his side make contact and asked those in the back if "we" were good? They indicated that it was OK. As it turned out the rear of the skids were still suspended somewhat. We need to not get in a hurry and accept "almost right", WE NEED TO DO IT PROPERLY OR NOT AT ALL.

09-0768: During routine inspection between fuel cycles a 1 1/4`` crack was found on the left hand pylon skin. Upon further inspection of initial crack, pylon bulkhead at pylon station 43.348, 4 additional cracks were found on left-hand side of bulkhead flange. CORRECTIVE ACTION: Submitters Comments: Sheet metalist arrived, fabricated and installed patches over cracks. MI notified, placed ship back in service, will visit site later in the day.
09-0775: Upon arrival at the fire we experienced bleed over of Mexican transmissions that rendered the use of the forest net unusable. This required us to shut-down the forest net and I advised the ECC to call us on the guard frequency should there be a need to contact us. In addition to this the air tactics frequency 166.675 had a constant static but we could pick up radio traffic. We tried to put this frequency on the other two fm radios but the static persisted. The static would go away if we went about ten miles from the fire. There is a large power transmission line that runs along the fire scene. The static was not present on any other of the air tactical frequencies. Due to the small amount of traffic we elected to stay with the assigned FM and relied on VHF radio. Had this been a more complex fire we would have requested the use of another air tactical frequency. CORRECTIVE ACTION: RASM Comments: Radio gremlins are difficult to sort out. The problems on this incident seemed to be worked through, but could have gotten to be a bigger problem if it had been more complex. One other thing that could have been done to help determine the problem may have been to ask other aircraft if they were experiencing similar problems.

09-0730: At about 1600 after the last flight for the day, while doing a post flight inspection the mechanic found a 2x2 hole in one tail rotor blade tip caps. He also found that one of the heat shield struts {cross bracing} was broken at one of the ends. CORRECTIVE ACTION: The tail rotor tip cap was replaced and a balance check was done on the trail rotor. The result was the tail rotor balance was still good. The heat shield strut is to be replaced this morning. UAO: Good post flight inspection by the mechanic. I am satisfied that all the right calls were made. The RASM and the Regional Aviation Maintenance Program Manager have been involved with the whole process. RASM Comments: Pictures were taken and reviewed by myself and the Regional Aviation Maintenance Program Manager. We are convinced that the damage to the tail rotor blade was caused by Foreign Object Damage {FOD}. There was no evidence of the blade striking anything: such as a tree limb. The size and location of the hole in the fiberglass tail rotor blade cap is consistent with the broken heat shield strut bolt. AMI comments: All procedures were followed.

09-0750: I have been dealing with a manager who I feel I am unable to express safety concerns with. He is extremely critical concerning my performance. he has been comparing me with other pilots. His criticism of the aircraft is one thing but, over the past 4 days has been directed at me personally. These comments have not only been towards me but also to my crew members and my 2 assistant managers. It is making doing my job much more difficult than it should be. It is also creating a safety hazard in that I can go to my manager with safety concerns without being ridiculed. This situation is affecting my ability to perform safely a pilot. CORRECTIVE ACTION: R5 RASM Comments: Both an Aviation STAT team, RASM and HOS spent a considerable amount of time working with the individuals involved here. Communications and mutual understanding both needed improvement here, as well as an adjustment in the relationships between the pilot and manager. Both agreed to work closer together with improved communications and mutual respect. It was also pointed out to the Manager that he needs to feel comfortable in saying No to outside requests for him to step up to helibase Management assignments on fires they are assigned to unless he has a qualified Manager there to assume that role. It was apparent that the manager had a significant workload supervising a HEMG {T}, and also had oversight as the assigned HEBM with a HEBM {T} at the same time. This contributed towards the feeling from the pilot that his concerns were not being heard. We will continue to monitor the situation to make sure things are working well.
09-0766: Helicopter was released from fire and was departing local airport enroute to home base. Approximately 20 miles NW of Cedar City airport we came head to head with a general aviation fixed wing. The manager saw the aircraft first and was able to point in the direction of the approaching aircraft and say “oh oh oh”. The pilot flared the aircraft to the right to avoid possible collision. The fixed wing appeared to not flare at all creating the assumption that they had not seen the helicopter. Shortly after the pilot contacted the fixed wing and they informed us that they had seen us and there was no factor. Our opinion is otherwise. Closing distance is unable to be estimated. Altitude difference is estimated at less than 50 feet. Ultimately it was a very close near miss. CORRECTIVE ACTION: Submitters Comments: Discussion following the incident involved the importance of voice activated communication. The manager would not have had time to communicate via ICS system without voice activated communication. We also discussed the importance of continuously scanning for other aircraft. FAO Comments: Great job of see and avoid.

09-0770: On 09/06/2009 during a bucket mission on the Fire, helicopter preformed a precautionary landing at an un-improved landing zone due to a chip light. Immediately after landing the pilots contacted air operations and the helicopter manager. CORRECTIVE ACTION: Submitters Comments: After receiving word of the incident the helicopter manager and the mechanic were flown to the site. The mechanic determined the light was indicating that a loose peice of metal was detected in the intermediate gear box in the tail rotor. A flush of this system was preformed, then the helicopter preformed a 0.5 hour run-up on the ground. Legal flying light ended causing the crew to delay until morning. The following day a hover was held at approximately 100 feet for another 0.5 hours. After landing the mechanic preformed another manual inspection of the gear box and returned the helicopter to service. The manager contacted the Regional Aviation Maintenance Inspector. The Inspector approved the helicopter to return to availability. We would like to give both pilots recognition for immediately recognizing the dangers of the situation and taking prompt and safe action in getting the helicopter on the ground. RASM Comments: Good job by the flight crew to put the aircraft on the ground where they were rather then try to fly it back to the helibase.

09-0753: Helicopter was in contact with dispatch for flight following en-route to the fire for a recon of potential helispots. Dispatch advised of helitanker also enroute and that he had the Victor freq. The HMGB tried to contact the Helitanker on the assigned A/A freq with no luck, but was able to briefly make contact with him on the airport Unicom before communications was unreadable. We contacted the IC on A/G and were told to go up and check for helispots for possible crew shuttles which we did. We closed out with dispatch and began flight following with the fire. After being on scene for roughly 30 seconds, all assigned freq.’s became clogged. We attempted to contact HT XXX on the A/A freq. again but could not talk because of a conversation about tactics and coverage levels between the incoming Air Attack and SEAT that were 30 miles out. Made several attempts to contact helitankers and dispatch with no success. Due to concerns about the incoming traffic and no como, the HMGB decided to fly back to airport. We tried dispatch on the repeaters with no luck, but due to Air Attack now talking on National FF we could not establish como. Air Attack was very concerned about where & when his relief was coming, who was on scene, as well as about lat/longs of dipsites. While we continued to wait for a break on the channel, after nearly 10 minutes we climbed up and raised dispatch on a repeater channel and gave them our vitals for a flight back. We were later informed by dispatch that the SEAT was told to not launch until aerial supervision was established. CORRECTIVE ACTION: Submitter Comments: We departed the FTA when we determined that we could no longer safely operate in it. After further analyzing the situation I recognize that I could have tried the Air Guard frequency to make contact with other aircraft and/or dispatch. FAO: Notified of issues by dispatch, Communications Techs notified of radio repeater issues for command frequencies, Great job by Type III helicopter to depart the area when communications became too clogged, ATGS came on scene and took over airspace with type I helo, and SEAT after the Type III helo departed.