SAFECOMs by Aircraft Type

For the month of July there were 78 USFS SAFECOMs submitted, well below the 10 year average of 207. Of the 78 SAFECOMs reported, 13 were airplane, 3 airtanker, 2 SEAT’s, 50 helicopter and 1 N/A. The chart below shows the percentage of SAFECOMs by aircraft type.

SAFECOMs by Category

Often there are more than one category assigned to a SAFECOM, resulting in a grand total of more than the total number of SAFECOMs. There were 4 airspace, 23 hazard, 23 incident, 39 maintenance related, 1 mishap prevention and 6 management SAFECOMs reported for this period. Below is the percent of SAFECOMS in each category.
SAFECOM’s by Category continued...

**ACCIDENT** - The best thing that happened in July is what didn’t happen! NO ACCIDENTS :)

**AIRSPACE** - There were 4 airspace events reported, of which 2 were conflicts at airports, congestion at a dip site and an FTA intrusion.

**HAZARD** - There were 23 hazard reports in July. Communication issues continued to account for nearly a third of all the hazard reports. They ranged from radios not transmitting, frequency congestion and management, aircraft communications at airport, deconfliction procedures with the DOD and avionic issues with the FM radios in an ASM platform. Pilot action was the next most reported and all had to do with bucket operations. There were two policy deviation reports: a flight after civil twilight on a rescue mission and a helicopter continuing flight without consulting a Regional Aviation Maintenance Inspector after making a precautionary landing.

**INCIDENT** - The most reported in this category were “Other” which were mainly rappel events that previously may not have been reported but are now as part of the Rappel Quality Assurance requirements. Precautionary landings were the next most reported, which were all maintenance related (chip, caution and warning lights/horns), nice job in making those precautionary landing and not pushing it! There were only 3 dropped loads and 2 dragged loads reported which are normally the most reported in this category.

**MAINTENANCE** - Forty-one percent of the reports submitted had maintenance associated issues. Avionics and electrical issues were the most reported in this category. There have been several issues reported with the TDFM-136A radios ranging from overheating, smoking, and programming issues. We are currently working on a Technical Bulletin, in the mean time make sure you contact your regional Avionics Technician if you experience any issues with these radios. Chip lights, caution lights, instrument and hydraulics each had 4 reports.

**MANAGEMENT** - There were 6 management reports, 4 internal and 2 external. Two of the internal were questions relating to the rappel program and the other two were on management decisions.

**MISHAP PREVENTION** - There was one report that gave a dispatch center kudos for making several calls to the military in order to ensure the airspace was deconflicted.

THANKS TO EVERYONE WHO COMPLETED THE SAFECOM SUMMARY. We received 476 responses; 340 federal, 43 state, 63 vendor and 30 other responses. We will begin reviewing the responses this fall and send out a report on the survey. We are looking forward to making the system better based on the issues and ideas that were submitted. We received numerous comments and we truly appreciate your time and effort to give us the feedback.
These are samplings from the SAFECOM’s submitted for the month of July. We hope you will select a couple of them a day to discuss and use the lessons learned in your daily briefing. Some of the SAFECOMs have been edited due to length, to read the SAFECOM in its entirety, please click on the link.

**SAFECOM 10-543:** A backhaul mission was ordered to be flown from division Zulu to a cargo receiving site. A 150 foot longline was being used, and the load weighed 1400 pounds. A private contract fire crew member hooked the load that was flown to the cargo receiving area. Upon arriving and lowering the load to the ground, the pilot noticed that the load would not release. The pilot tried twice to remotely release the load. After two failed attempts to release the load, the pilot requested that cargo personnel manually release the load at the hook. The cargo personnel who released the load noticed that the load was improperly hooked. The swivel ring that holds the load to the hook had been placed on the u-shaped keeper. The oval ring on the swivel was completely outside the area to be used to hook loads. The first picture shows the manner that the load was hooked. The second picture is how the hook is intended to be loaded. **CORECTIVE ACTION:** FAO comments: AAR with incident crew occurred at Helibase. Excerpts of AAR: What happened...Hook placed on ground at pick site and Hooker hooked load. Instead of sliding swivel ring over load-bearing beam of remote hook (past the keeper), Hooker manually opened the remote hook, moved snout of hook completely open, and place the ring of the swivel over the ¾” U-shaped area of the keeper. Hooker did not feel entirely comfortable with the hookup but was somewhat nervous/unfamiliar with the procedure and did not communicate any issue. What went well...Helibase manager decision to change the requested mission (from delivery to Hamilton~12NM to delivery to Cargo site~2NM) to minimize flight time with an external load was indicative of good decision making that should be a part of standard aviation risk management, and may have prevented a dropped load incident. What did not? Planned and utilized Hook-up person was not certified for the mission (no HELR rating). Plan for single person hook up was not necessary (normally 2-person mission). 1400# load was transported by a non-load bearing part of the remote hook (keeper). Lessons learned/corrections: Crew will only utilize officially certified personnel for any mission in the future. Crew will assure that a trainer accompany any personnel in a training position. Company will plan for enhanced/additional aviation/longline training for crews, to include A-219. Potential for such a miss-hook-up has been communicated to the aircraft vendor, the incident crew, and the helitack crew, has been distributed nationally via a SAFECOM and will help in future incident prevention.

**SAFECOM 10-542:** Air Attack (AA) platform was dispatched to two small fires. The order included information that a helicopter was also requested. On board the AA was the pilot, a qualified ATGS (backseat), and myself a trainee ATGS (front seat). At approximately 1015, I made contact with two incident commanders present on the ground and proceeded to identify the exact location of the fires, risks, potential helispots, dip-sites, etc, and discuss objectives with the ICs. At approximately 1040 I called the helicopter expecting they should be within 12 miles and also to confirm they were en route. When the helicopter answered I advised of altimeter, and AGL/aircraft clearance. The Helicopter pilot confirmed transmission. Upon hearing this radio traffic the pilot of out AA alerted me that the TCAS showed an aircraft had just passed directly underneath us. The separation between aircraft was approximately 800 to 1000 feet. To Recap, initial contact was not made at either the 12 or the 7 mile perimeter and the helicopte-
fer entered the FTA without clearance. **CORECTIVE ACTION:** After I confirmed visual with the helicopter, I reminded the pilot of the need to obtain clearance before entering the FTA. The pilot confirmed that s/he would do that next time. In review of this incident the ATGS trainer reminded me that I failed to called ‘‘into the blind’’ before entering the FTA. Had I done so, the helicopter pilot may have heard this radio traffic and more likely have been reminded to contact me at 12 miles out. This issue was also discussed with the Helicopter Manager. The manager will remind the pilot of FTA protocols and policies. FAO comments: Discussed with ATGS next day at Dispatch. No other actions taken other than stated. ACTING RASM Remarks, Great lesson Learned (KUDOS) and hard at times to admit ones own mistakes, but awesome job of recording the incident so other can learn from the experience. Additionally, alert pilot of the TCAS notification. Good reminder of the FTA. All please share this SAFECOM with your units.

**SAFECOM 10-539:** At 2000 Helitack was alerted about a possible medevac. The patient was a member of an NYC crew with a possible spinal injury from a fall after a seizure. Due to the nature of the agreement between the USFS and NYC, as well as, hesitation on the part of the Recreation Department the decision to send our helicopter for the medevac was delayed. We launched from helibase at 2100. Civil twilight was at 2144. We arrived over the area around 2115, and identified an appropriate LZ. All three helitack members aboard were watching rotor clearance and in communication with the pilot. We landed at 2120. Helitack performed patient assessment and took precautions for a possible spinal injury. The plan was to fly the patient in a seated position a short distance to an Airstrip, where Life Flight would meet and pick up patient and we would return to the helibase within civil twilight. Dispatch informed helitack that the nearest Life Flight available was 45 minutes out. Helitack then made the decision to fly the patient to town where the patient could be handed off to Life Flight or the local ambulance, as needed. The Forest Aviation Officer was advised at 2138 that we would be flying past civil twilight. We lifted off the medevac site at 2150. Light conditions were low, but roads, peaks, and other topographical features were still identifiable. The helicopter manager was very familiar with the area and could determine the helicopter’s location without the use of GPS or map. Upon approaching the Airport the runway lights were activated by keying the mic on the unicom. An ambulance and fire truck were shining their headlights towards the compass rose where we landed without complication at 2216. We shut down for the night. On 7/30/2010 an AAR was conducted with the Pilot, Helicopter Manager, the 2 Helitack members present, the Dispatcher, Dispatch Center Manager, Forest Aviation Officer, District Ranger, and the Recreation Department. The purpose of the AAR was to determine the un-timeliness of the decision to launch the helicopter. **CORECTIVE ACTION:** FAO Comments: The forest conducted an AAR of this incident and identified several discrepancies in the emergency response requirements/expectations for these types of resources. We are currently in the process of developing protocol for possible future incidents. The helitack crew did a good job of mitigating known hazards. All appropriate personnel were notified of the policy deviation.

**SAFECOM 10-538:** In flight during fire operations the FM1 digital radio 136A emitted smell of hot wires, no smoke was visible. During the previous 3 operational days the radio demonstrated odd frequency un-programmed changes in both Rx, Tx and tones. At times the radio did not receive nor transmit even though the frequencies displayed correctly. **CORECTIVE ACTION:** During the apparent degrade leading to failure of the radio, determining the problem or failure became allusive and inconclusive at first. This was compounded by the digital 136A being new and new programming required. Mastering programming features and recognizing un-programmed changes will lead other users to determine failure before experiencing the smell of hot wires. The radio was removed, repaired and returned to service and availability. RASSM Comments: Spoke with Avionics Inspector and all procedures were followed
**SAFECOM 10-531:** Helicopter left helibase for a sling mission of 2 blivets. Upon arrival on the fire the pilot experienced a main gear box chip light. Pilot immediately returned to helibase and shut down. Mechanic noticed enough metal shavings to be concerned. They replaced the fluids and a filter. They did an hour test run and found no problems. We contacted the Regional Aviation Maintenance Inspector (RAMI) and he talked with the mechanic and then put the aircraft back into contract availability. It was recommended by the RAMI to monitor the main gear box after 3 hours of flight time. **CORECTIVE ACTION:** The mechanics switched out the fluids and filter, they checked the new filter and oil after 1.8 hours of flight time and found no problems...... Acting RASM Remarks, I concur with RAMI. Perform additional inspections till the comfort level and no additional metal shows up any longer! RAMI: The mechanic called this morning about 1030. I requested a re-check of the detector and he found some debris. They are planning on returning to base and the company is sending a replacement transmission.

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**SAFECOM 10-525:** As HXXX was approaching the ‘Lower Dip’: the pilot informed HYYY that he was making his descent on the opposite side of the river. HYYY had just had acknowledged his traffic when HXXX noticed civilians rafting approximately 1/8 of a mile upstream of the dip site. He initiated a 360 degree turn to his right to allow the raft to vacate the dip site. Upon completing the turn, the pilot noticed the rafts had beached on shore. HXXX was completing his final approach to the dip site when he noticed that another helicopter appeared on his left side heading for the same dip site. The Pilot stated that there was approximately less than 150 feet between the two helicopter rotor tips. HYYY witnessed the event from his dip site and asked if ‘you guys’ had seen each other. The other helicopter involved did not reply while HXXX did acknowledge HYYY’s traffic. HXXX tried to raise HZZZ on the Victor VHF a couple times without success. HXXX then tried to raise HZZZ on the FM Air to Ground when the HZZZ pilot raised HXXX on the Victor. HXXX asked HZZZ if he realized that they were both involved in a near miss incident. The HXXX pilot then terminated the rest of his mission and informed the Air Attack Pilot on what had transpired, he also informed them that he was returning to the Helibase. **CORECTIVE ACTION:** Upon completion of the second parties’ mission, a meeting was held with manager and pilots with the involvement of the ASGS and ASGS Trainee to find out the details of what had transpired. Both pilots agreed that there were too many aircraft (5 total) in the same dip site. Radio traffic was also congested on all assigned frequencies. All parties acknowledged that there was a lack of communication. Both pilots agreed that better communications with all pilots and a predetermined alternative dip site with dip site manager as well as an assigned HELCO will aid in the prevention of such incidents. RASSM Comments: After this incident the Helibase Manager stopped the operations and separated the dipsites by bucket and tanked helicopters, develop egress and ingress routes for the dip sites, and created designated dipsite therefore the helicopters were not just going anywhere on the river. Freelancing for dipsites on the initial fire happens all to often, we need to assure from the begin that protocols are in placed and shared with the pilots to prevent this from happening again.

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**SAFECOM 10-524:** While on a fire reconnaissance mission the aircraft encountered hail in flight: resulting in a series of small dents to the leading edge of the wings and horizontal stabilizer. There were several areas of falling precipitation in the area, and a route was selected to avoid obvious areas of heavier rain. Despite flying through an area of relatively light precipitation, sufficient hail was present to damage the skin of the airplane. The encounter was brief, and with clear air ahead, the decision was made to proceed on course. No damage was detected in flight, and the mission proceeded normally. Upon landing, the damage was noticed and the vendor owner and company mechanic were notified. The next morning the vendor notified the pilot of the manufacturer specifications for surface damage, and inspection revealed that some of the dents exceeded those specifications. Once this determination was made, the airplane was taken out of service and dispatch, the UAO and RAMI were notified. **CORECTIVE ACTION:** An
amendment to the contract has been completed for a replacement aircraft by the company. A substitute air attack platform was ordered for coverage on the unit until the replacement arrives. Briefings continue to cover hazardous conditions that can be encountered while working around thunderstorm activity. RAMI was contacted and arrangements were made to provide a substitute aircraft. All procedures were followed.

**SAFECOM 10-523:** When taking off from helibase, onboard aircraft manager had difficult time contacting dispatch due to afternoon weather broadcast. Manager finally made positive contact with dispatch. En route, the pilot had to sharply bank right to avoid an oncoming SEAT flying at the same level as the helicopter in the opposite direction approximately 1/8 to 1/4 mile distance. The manager/pilot had been uninformed of any aircraft in the area. **CORRECTIVE ACTION:** During both initial and extended attack, all aircraft need to be aware of potential airspace conflict via local FF, National FF, local A/A or Air Guard. All aircraft should monitor local A/A when travelling in/out of associated airspace. Helibase will land line dispatch with flight plans before flying. All flight crew members need to maintain heightened awareness when conducting any aviation operations to ensure pilot is aware of all aerial hazards....FAO comments: This scenario is an aviation “Watchout”. If positive communications for flight following is not established in a reasonable time, managers need to reassess if the flight should continue. Situational awareness must be maintained during “ALL” aviation missions and heightened during heavy fire activity. Alternate frequencies, “NFF”, “Air Guard” should be used as needed. Contact dispatch with flight information prior to lift-off via landline.

**SAFECOM 10-520:** Our mission was ASM on the Fire. At one point I was transmitting on AM #1 on a frequency of 125.175. The ATGS had this radio de-selected on his audio control panel. He heard my transmission on FM #2, on a frequency of 167.9875, and also 168.1250. He only heard my transmissions when he was receiving another incoming transmission on this radio either from dispatch or ground resources. So my outgoing AM transmissions were going back to the FM on an incoming FM transmission. The sound had an over-modulated sound to it, and the ATGS was unable to understand the original incoming transmission. Before transmitting on the AM, I had to make sure the ATGS was not receiving an important incoming FM transmission. I had numerous aircraft on scene at this point, and this situation had an adverse affect on safety and overall utilization of us as an effective ASM resource. When we were returning to base, the ATGS was transmitting to dispatch on FM #1, on a frequency of 168.650. I had this FM radio de-selected. Whenever he was transmitting, my #2 AM radio was completely blocked by loud static, and I was totally unable to understand this radio. The frequency on this #2 AM radio was 135.175. **CORRECTIVE ACTION:** RASSM Comments: Spoke with the pilot and he will not be operating as an ASM. The only capacity he will fly as is Lead Plane or Air Attack, but not as an ASM until the radios meet the mission of an ASM Platform. This issue has been elevation to the national level. More to follow.

**SAFECOM 10-515:** The aircraft was working bucket drops on DIV A. At this time, the ship came over the ridge with a full bucket, over flew the drop area, hovered with minimal forward movement doing a right/clockwise turn, and put the bucket on the ground. No personnel were in the immediate vicinity so no injuries occurred. Talked with the helicopter and trainee manager on 7/27/10 and after they talked with the pilot, the pilot said he put the bucket on the ground on purpose because it was spinning. To do this in the fire area (30 acres) on purpose is not an appropriate place to do this type of action. The concern with this incident is that other personnel on the fire worked with the ship the night before and mentioned the pilot had hit tree tops with the bucket. **CORRECTIVE ACTION:** RASSM Comments: I sent the HIP down to assess this pilot, and I am comfortable with his findings. I appreciate the Helicopter
MGR and ground crews for bringing this to our attention. HIP - I met with the pilot, as well as the owner and relief pilot, today. I started off visiting with the manager and manager trainee. After spending some time with the pilot and observing his long line control, I feel that he is a very competent and mature long line pilot, with good experience and skills. He is not new to the fire environment, but does have a history of production flying, and these tendencies will occasionally sneak into his fire flying. I don’t think he is unsafe: he and the owner expressed a strong desire to give their customer, USFS, top performance. I stressed that top performance is not directly linked to speed-loading buckets, and we are more concerned with a safe smooth flowing operation. His problem with the bucket contacting the ground was due to encountering some down draft and settling tendencies after crossing the ridge. I agree that could have certainly happened, but I pointed out that he would have anticipated these conditions had he not been in such a rush. The previous event was similar, he got the sun in his eyes at just the wrong moment, and it would have been avoided with just a little more altitude. I stressed the importance of PIC responsibilities and his word as final authority for that aircraft. I stressed slowing down a little to better ensure the outcome of his efforts, and our desire for a safe operation. We discussed interaction with ground crews and overhead in the fire environment. I asked a few pointed questions from IHOG which he answered correctly with no hesitation. I also stressed to him that no one is after him and he’s not in trouble. However, with two load-to-ground episodes being looked at, there are some `raised eyebrows’ and another episode would result in more scrutiny. We had a positive visit, and I am certain that we are dealing with a good pilot and good company, that just want to do their part. He will be flying slower and higher from here on out.

SAFECOM 10-507: Tanker departed airport with instructions from the Ramp Manager to hold at his discretion with active lighting cell west of airport. The PIC studied his radar and decided to depart with an immediate turn to the north. Airbase operations were then shut down through the dispatch center until the storm passed. Twenty minutes later on way back from incident 089 dispatch informed the Tanker of storm near airport: pilot circled several times and observed VFR conditions and proceeded to land without incident. The SEMG visited with visiting a/c SEMG and received follow-up phone call from pilot. CORRECTIVE ACTION: This airport being on a ridge top is prone to fast moving storms that have the potential to be a hazard. SEMGs and pilots need to be vigilant and remember that fire suppression does not preclude safety. Each member of the team has the responsibility to suspend operations if deemed necessary. RASM Comment: Good to share weather hazards as a heads up for all. UAO Comments: Recommend discussions of alternate airstrips {for diversions} and adequate fuel loads to accommodate diversions as well.

SAFECOM 10-504: I was on a mission to supply a net load of water and sleeping bags to a crew at fire 180. They called me into the spot which was in 120 foot trees: I was using a 150 foot longline. I brought the load into the site, I watched the loads shadow come into ground contact and was sure that the load was just touching the ground when I hit the release button. I returned to the airfield, where we were then told that the cubees were punctured, since the load was 10 feet off the ground when released. CORRECTIVE ACTION: Crew and PIC communication SOPs to be followed when working with an external load. AAR with pilot was completed immediately after landing and a crew AAR was completed the following day. RASM Comment: When you send a helicopter to perform a longline mission consider the drop-off point. The pilot is flying the load by watching the load from the left front door, called vertical reference: so if the drop-off area has shadows then determining when the load is touching the ground will be difficult for the pilot. Ground crews need to be communicating to the pilot any hazards in the area and inform the pilot they will advise when the load is on the ground, this should be normal ops and pre-planned. Reference Unit 4, A-219 Longline Training.
SAFECOM 10-502: Helicopter with pilot and manager on board landed at a remote helispot to pick up 2 passengers who had been dropped off earlier in the day. Upon landing the manager exited the aircraft and began unloading a duffle bag with PPE for the passengers (flight helmets and survival vests), with the aircraft running. The manager then noticed that one of the passengers was approaching the aircraft without proper PPE, namely a flight helmet or hardhat. By the time the manager was able to get the attention of the passenger, the individual was already underneath the rotor system and in the act of setting down a daypack near the front of the aircraft. The manager immediately escorted the passenger out of the area where the person donned proper PPE, and the pickup and return flight then proceeded as normal. CORRECTIVE ACTION: FAO Comments: Helicopter Manager notified FAO at the earliest opportunity. Helicopter Manager re-educated the passenger. RASL Comments: Actions and corrections will be stressed at future training opportunities.

SAFECOM 10-501: During a proficiency rappel at the airport a rappeller sitting in seat 4 was given the signal to hook up to the descent device from the spotter. After receiving the signal, the rappeller proceeded to hook up with the descent device oriented incorrectly (thumbscrew to the left). The spotter caught the error and stopped the rappeller from proceeding further. The rappeller was directed to unhook, return to their seat and fasten their seatbelt. The rappeller in seat 3 was allowed to continue their rappel sequence: the spotter de-rigged the ropes/descent device and landed back at the airport with the 1 rappeller on board. CORRECTIVE ACTION: The rappeller met with the qualified spotters upon returning to the base and was debriefed on their thought process during the flight and any other contributing factors that may have played a role in the error. The rappeller was informed that the error was then to be documented on the R-6 weekly rappel report and that a SAFECOM would be generated. An R-6 check spotter was also informed. RASM Comment: Reporting Rappel issues in the SAFECOM system is part of the new Quality Assurance process established within the National Rappel Standardization Program.

SAFECOM 10-498: Sheriff notified Incident Command Post of an incident where a case of bottled water and a single plastic “Hefty” bag of trash, from a marijuana cultivation clean-up site, fell from a cargo net. The details of the incident were documented from the military liaison assigned to the operation. During routine sling load air operations debris fell out of the cargo net in flight. The cargo net was loaded with various infrastructure items removed from an eradicated outdoor marijuana cultivation site. During the course of the operation numerous flights took place sling loading infrastructure from the grow site to the HLZ transiting a minor two lane road and the river switch station. During one of these routine flights from the reclamation site to the dump site several items came loose from the cargo net and struck the ground in and around the River switch station. A civilian at the scene witnessed the debris falling and a case of water inside a reclamation bag struck the ground approx 10 yards from him, another bag with debris struck the ground approx 50 yards away from him. The civilian gathered the materials and drove them to the HLZ and made contact with the USFS LEO supervisor onsite and was briefed of the reason for the debris falling and was given POC info for the operation and left without wanting to file a complaint and expressed his gratitude to the operation. After details of the incident were obtained and the specific cargo net in question was located and found to have a hole in the bottom of the net {see attached photos}. It appears the case of bottle water fell out of the net though the hole in the bottom. It is believed the “Hefty” bag of trash likely worked its way out of the top of the net due to forward air speed and the fact that square net configuration does not allow for the net to completely enclose the contents inside. The cargo net in question was provided by the military. The style of cargo nets used by the military does not have the ability to be cinched closed by draw ropes. CORRECTIVE
ACTION: After this incident occurred, reclamation operations were suspended until all personnel associate with reclamation operations received remedial training in loading cargo nets. In addition all military provided “square” nets were removed from further use during this operation and mandated only USFS-LEI provided cinch style cargo nets are used. RASSM Comments: It is important to inspect equipment before the mission begins regardless who the provider is. The mitigation the USFS-LEI provided to prevent this type of incident happening was good “Risk Management”.

SAFECOM 10-489: During the morning preflight the mechanic discovered that the scissor assembly bushing had become unbonded. CORRECTIVE ACTION: The scissor assembly was replaced with a spare from store. Acting RAMI was contacted and the aircraft was placed back in contract availability. RASM Comments: Good catch by the mechanic conducting a thorough pre-flight. No further action required.

SAFECOM 10-484: Mechanic comments: Was servicing the oil on the top of the wing when the oil handle would not release. In attempting to direct the nozzle over the leading edge, I slipped on some oil on the top surface of the wing, and slid forward over the leading edge. I landed below on the ramp. Asst. ATBM Comments: Received phone call from fuel vendor that mechanic fell off the right wing of T-XX, that he was OK but needed someone to check him out. I observed the mechanic laying on the ground. I paged for an EMT to report to pad 5 and then called 911 for an ambulance. Mechanic was up and walking when ambulance arrived. Mechanic was examined by paramedics and cleared. Vendor then took the mechanic to the ER for a more extensive examination. From my conversation with the fuel vendor they were finishing filling the oil reservoirs when the nozzle failed to close. In the process, the mechanic stepped in the spilled oil fell to a sitting position on the leading edge of the wing, then slid off the edge feet first, landing on his feet then rolling to the ground absorbing his fall with hands and arms. Mechanic reported to work on time this morning a little sore but good to go. CORRECTIVE ACTION: Asst ATBM Comments: Fuel Vendor repaired nozzle. Oil spill was cleaned up, less than 5 gallons. Wing surface was cleaned. Removed all slipping hazards. Advised mechanic that he had used up one of his nine lives and to please be careful. RASSM Comments: Close call and lucky that the injuries were not more severe. Good job with the medical response.

SAFECOM 10-479: While preparing for launch to an initial attack, the Manager performed his walk-around to ensure the aircraft was buttoned down/ready for flight. The manager then noticed that the exhaust cover was in place and removed it prior to start up. CORRECTIVE ACTION: Manager informed the pilot and crew and later debriefed and stressed the importance of a pre-flight walk-around. Pilot will ensure all covers, tie-downs etc. are removed during morning preflight and not replaced until end of shift or unless adverse weather requires them. Good catch by manager. Never underestimate the importance of the walk-around and teamwork.

SAFECOM 10-478: During water dropping mission, the helitanker was a very short distance just south of the airport and noticed that the hydraulic pressure gage fluctuate. The pilots then proceeded to the airport and landed. After notifying the mechanics of the problem, the mechanics and pilots decided to shut down the aircraft due to the concern of possible hydraulic leak and a negative result being a fire. CORRECTIVE ACTION: The aircraft was shut-down and the mechanics began inspecting and discovered a hydraulic leak. The pilots and mechanics advised me of the situation and I notified the RAMI. Upon further inspection the mechanics discovered that a servo o ring on the 1st. stage side of the right lateral servo on the upper portion of the aft side had blown a seal. The mechanics replaced the defective part, replaced the fluid inspected the hydraulic system and completed all necessary inspections according to the manu-
factures specifications. After aircraft run up and inspections according to the manufactures specification no other problems were found. I then contacted the RAMI of the status and corrective action. The RAMI was satisfied of the outcome and advised to return to contract availability. RASSM comments: Good call on the contractors part to return to the airport and trouble shoot the problem. This is considered “Best Practices” and is the expectation of the Region. Good job!

SAFECOM 10-474: While spooling up on the ground for proficiency rappel a loose item was noticed approximately 75 feet behind and to the side of the helicopter caught in a dust devil. The helicopter mechanic and crash rescue personnel noticed the object and immediately secured it. The object was found to be a sleeping pad that had been used by the mechanic and pilot while cleaning the underside of the aircraft. The pilot stated that it had blown away and he had forgotten about it. The mat had blown against the airport perimeter fence and had stayed there until the dust devil caught it. CORRECTIVE ACTION: Pilot and crew discussed the necessity of securing loose items and FOD checks on the deck. Crew and pilot also discussed following up on events that seem unimportant at the time, but become larger issues later. RASM Comment: Sometimes it’s the little things that can get you. Good catch and thanks for sharing as a reminder to others.

SAFECOM 10-462: Problems were encountered while programming a Technisonic 136A {P25} radio. Upon initial powering on of the radio a message appears on the screen “Boot loader Software Version Installed.” At that point the radio should enter into normal functioning mode, however this radio would not. It remained “locked up” and would not change to normal operating mode. This radio was stamped new June 2010 and had not been programmed in the field prior to this attempt. The contractor contacted Technisonic and no field fix was available. The contractor also stated that they have had trouble with the new P25 radios on multiple occasions. CORRECTIVE ACTION: The P25 radio was removed from the aircraft and replaced with a like item. The radio that was not functioning correctly was shipped to Technisonic for diagnostic testing and repair. RASM 7/17/10 after some follow-up on this and several other reported Technosonics issue it appears that a recall is in motion and to expect the newer models to experience problems. Please take some time to look at the Technosonics radios you have on board and make contact with technosonics to ensure you are not currently using radios that are experiencing difficulties.

SAFECOM 10-450: On a bucket operation mission the bucket came in contact with a knife ridgeline with embedded sharp rocks. Pilot was setting up line and airspeed for the target while clearing the ridge by approximately 30 feet. Aircraft experienced a sudden downdraft and pilot’s reaction to counter act the sink rate was unsuccessful resulting in the bucket contacting the ground. No major equipment damage to aircraft or bucket. CORRECTIVE ACTION: Pilot reported incident to air attack and helicopter manager. All necessary parties were notified. The following mornings briefing contained an additional discussion about safe, conservative bucket operations in steep terrain and turbulent conditions. UAO Comments: Discussed w/Helibase Mgr, who discussed w/all in morning briefing. RASM Comment: Thanks to the pilot for sharing his bucket experience so others can learn from this event. Firefighting is challenging and sharing events like this provide learning opportunities.

SAFECOM 10-447: Helitack Crew has been conducting work on a trail fuels project during the 2010 field season. Project spans 9 miles of trail. It was planed to sling a “Job-Box” containing saw, fuel and parts into various sling spots on the trail to cut down on crew fatigue during the daily hike in and out and to optimize production rates. P.A.S.P completed for this project and JHA for external cargo operations was reviewed and signed. With crew in place at sling site the helicopter was configured for longline and the remote hook checked for proper operation. From the cargo spot the aircrafts flight profile required a
south departure and climb out over the water of the a dam. Approximately two minutes into the flight a transmission over the radio from the crew member at the sling site said “helibase the load is in the water”. Pilot returned to helibase and shut down. Pilot stated “I did not know the load was gone until the transmission came over the radio that the load was in the water”. The load sank out of site, all was lost. CORRECTIVE ACTION: Upon returning to the base the mechanic was notified of the lost load. Mechanic proceeded to check all electrical connections, 100 ft longline inspected for wiring and insulation, no problems found. Collective and release trigger inspected in aircraft, no problems found. Remote hook pigtail and release solenoid inspected for wiring, insulation and continuity problems, none found. During these standard checks of the electrical systems it was discussed that the pigtail cable on the remote hook had signs of wear and some amount of memory in it from riding against the manual release knob and this was induced by wind drag (pic 1). Looking into this further its was conceivable that the cable could wrap around the manual release knob in multiple ways and with added wind drag this could inadvertently release the load (pic 2 & 3). It was also pointed out that the manual release knob was very sensitive and took less than 5 psi to release the hook. Corrective Actions: remote hook pigtail was configured to the opposite side of the manual release knob and can no longer interfere with manual release (pic 4). Aircraft was then configured for longline and a test load flown with no further problems encountered. The Helitack Crew, RO HOS, RAO, and contractor personnel spent many hours of down-time evaluating the remote hook and possible scenarios and I give them credit for coming up with the corrective action. There are no wiring instructions given by the manufacture other than stating “Standard wiring installation has been left to the operators’ discretion”. Good troubleshooting. RAO also commented on the excellent PASP that took into consideration the route flown by the helicopter with the sling load and fatigue of the crew. Helitack managers please share this with your crews for future reference: please spread the word about a good corrective fix for the incident. Well Done! No Further action. P.S. The category I selected was “Dropped Load, Human Factor” this incident was a result of lack of human engineering by the manufacture for identifying specific procedures for wiring installations. I will also contact the manufacture of the incident.

SAFECOM 10-445: We made a standard 45 degree pattern entry at traffic pattern altitude to runway 30 at the airport: the pilot made position calls on the airport advisory frequency from 5 miles out, 3 mile extended 45, entering downwind and every turn in the pattern. We communicated with an aircraft holding short of the runway as to our position abeam the numbers. The aircraft holding short taxied onto the runway and departed. Shortly after turning onto final we heard an aircraft call on the radio saying “Aircraft on final, you are above me.” The pilot of our aircraft immediately added full power to begin a go around. we observed the aircraft 200-300 feet below us make an immediate 90 degree left turn off of final and continue in that direction. We were on a one mile final and in a position to land: the pilot continued and landed the aircraft. CORRECTIVE ACTION: In summary, I the pilot failed to see an aircraft entering the traffic pattern at the same time we were entering the pattern. Throughout this event the pilot and the ATGS onboard did not hear a radio call from or see the other aircraft in the traffic pattern until he made his presence known on final. The evasive maneuver on my part was to execute a go around procedure.
Continuing with the go around would have been the best choice to make at the time. Corrective action is to maintain extra vigilance to see and avoid other aircraft while flying and especially in the airport environment. RASM Comment: The Unit Aviation Officer {UAO} and the Regional Light Fixed Wing Manager talked to both pilots. This is a see and avoid issue.

SAFECOM 10-442: During routine inspection a crack was discovered on right main landing gear on lower torque arm at the grease zert where the two arms are bolted together. These torque arms are to ensure correct alignment of wheels on right and left sides and alignment of wheels in strut. Both arms have been ordered and will be replaced today. CORRECTIVE ACTION: Both torque arms on the right side were replaced. Work was completed at 1315, 07/10/2010. The aircraft was returned to contract availability upon completion of work as per my conversation with regional maintenance personnel. RAMI: All procedures were followed. I am glad to see that daily inspections are thorough enough to pick up such a problem. It looks as if all the right people were involved with putting this aircraft back in availability. (UAO)