SAFECOM Summary
June 2011

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SAFECOMs by Aircraft Type
For the month of June there were 130 USFS SAFECOMs submitted, slightly higher than the 10 year average of 103. Of the 130 SAFECOMs reported 19 were airplane, 19 were airtanker, 5 were SEAT, 83 were helicopter and 4 were 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 NO accident, 15 airspace, 30 hazard, 25 incident, 74 maintenance related, 1 management and 5 mishap prevention SAFECOMs reported for this period. Below is the percent of SAFECOMS in each category.
SAFECOM’s by Category continued

**ACCIDENTS** - There were no accidents in June, and no accidents for this fiscal year. We had two events that were both classified as Incidents With Potential (IWP). One was a SEAT that suffered wing damage during a go around maneuver. As the aircraft ascended, the left wing impacted a runway identification sign. The aircraft landed successfully on the second attempt. The other was a CH-54, that had the snorkel swing and break the right side chin bubble. Fortunately there were no injuries in either of these events.

**AIRSPACE** - There were 16 airspace events reported, of which 5 were intrusions, 5 conflict and 5 congestion. While none of the events were classified as near mid-airs, with the number of these “close calls” reported in such a short time frame, a closer look into the events was conducted by the Enterprise Team Air Safety Investigator. A summary of the findings and recommendations are available in Inter-agency Accident Prevention Bulletin11-03.

**HAZARD** - There were 30 hazard events reported. Communications accounted for a third of the hazards reported. Issues most common were aircraft unable to contact each other, communications processes, microphone issues, and ground radios and frequency management. Flight following and instructions were the next most reported.

**INCIDENT** - Reported in this category were 5 precautionary landings and 2 forced landings; an air attack platform and a heavy helicopter. There were 2 dragged loads, 2 dropped loads and 2 aircraft damage reports. Twelve incidents categorized as other included: rappel procedures, PSD operations with an loss of tail rotor effectiveness event, communications/instructions with loading a VLAT, and two events with personnel in the front seat of helicopters.

**MAINTENANCE** - Issues involving maintenance were present in 50% of the SAFECOMs, which is normal. There were 74 maintenance reports, the most reported were a variety of engine issues, electrical problems and chip lights.

**MANAGEMENT** - There was one internal management SAFECOM reported regarding how the grounding of an aircraft was handled.

**MISHAP PREVENTION** - There were 5 reports in this category: 2 instances of outstanding maintenance by vendors, pilot discontinuing mission due to weather, use of standardized dispatch forms and pilot catching fueling mistake (this is why it is critical for pilots to monitor fueling procedures).

**Why should I write a SAFECOM?**

A pilot recently said to me “Why should I write a SAFECOM” we had an AAR with everyone involved and resolved the issue, problem solved! While that is the proper on the spot corrective action, how can we measure the hazard/incident in terms of frequency and severity if we have no data? Fixing the problem throughout the system requires more than the on the spot correction, we need to get to the root cause and fix it permanently. By having a reporting and learning culture we can share the information with all aviation entities to maximize the potential of managing the risk.
“I’ll be punished, demobilized and may jeopardize my company from future contracts”

Another pilot was concerned about writing a SAFECOM because he was afraid it would be used against him, or his company in the contract evaluation process. The Forest Service has addressed this in policy and the USFS Safety Management Systems Guide, Chapter 4.3.1 states: The following are examples of how SAFECOM information MUST NOT BE USED: Contracting: Managers must not address SAFECOMs in their daily diaries since the diaries are used by Contracting Officers. While safety events may need to be documented in the daily diary, it is strictly prohibited to mention that a SAFECOM was filed or to attach a SAFECOM as a record. Contractor performance evaluations: the Federal Acquisition Regulations (FARs) section 42.1503 addresses the government requirement for holding past performance information. The SAFECOM does not meet the requirements of the FARs as an acceptable past performance record. Therefore, SAFECOM records/data are not to be referenced when evaluating past performance for any contract solicitation. Disciplinary Action: SAFECOM’s are not to be used punitively in disciplinary actions against agency or contract employees or contractors. This includes Performance Evaluations, Pilot Evaluation Boards or Suspension/Revocation of a USFS Qualification Card. Misuse of the SAFECOM system will not be tolerated and should be reported immediately to the Aviation Safety Office at 208-387-5285 or 208-387-5607.

SAFECOM’S

These are samplings from the SAFECOM’s for the month of June. 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 SAFECOM’s have been edited due to length, to read the SAFECOM in its entirety, please click on the link.

SAFECOM 11-572: During an initial attack lightening fire on county land two helicopters were launched, one by the County Fire and one by the USFS. The County representative attempted to notify Dispatch of the launch of N-COUNTY but the entire phone system of dispatch was down and not notified. H-FED arrived and the crew noticed H-COUNTY preparing to initial attack the fire with water bucket. The crew of H-FED attempted to make radio contact with H-COUNTY via A/G, I.A. Victor, and the Command frequency with no success. The manager of H-FED made contact with the fire IC on A/G, radioed in a size-up, and notified dispatch of the launch of H-FED and again attempted to make contact with H-COUNTY to no avail. CORRECTIVE ACTIONS: Once H-COUNTY was airborne enroute to the fire with water bucket and no communications, H-FED notified dispatch of the lack of communications between the two aircraft, disengaged and returned to base. We had a sit down AAR with the County, Fire and Rescue, BLM and the Forest Service. Unfortunately the Park helicopter was not present at the AAR. The extent of the main problem was essentially frequency management, unified command and complex airspace. The 2 helicopters did not have communication with each other as one aircraft was operating on Forest frequencies and the county helicopter was operating on County frequencies. To further complicate things the dispatch office phone lines were down and the county could not notify them that they had launched a helicopter. Obviously lots of hole lining up in the swiss cheese. During the AAR we addressed concerns that we have from an agency standpoint and came up with some standard operating procedures for the county dispatching aircraft to fires. The county agreed that if they launch an aircraft that initial contact will be made with dispatch on the National Flight Following frequency and via phone with the dispatch center to let them know of their intentions. Although the fire was not complex in nature, the jurisdiction and potential for unified command, 2 helicopters operating within a confined piece of airspace and lack of communication is hazardous. Following the FTA protocols as well as abandoning operations if communications cannot be made are both relevant in this situation. RASM 7/06/2011 Great follow through by the unit. Remember, Guard is always an option to make initial contact. The response was right on with FTA protocols, no communications, then return to base.
SAFECOM 11-552: The mechanic for the Air Attack platform was performing maintenance on the aircraft. Helicopter XXX arrived at the airport as assigned and taxied along the taxiway passing the Air Attack aircraft while maintenance was being performed and caused enough disturbance in the air that the mechanics tools and other loose items were spread around the ramp and adjoining parking area. The helicopter then turned around and taxied back down the same taxiway and passed the Air Attack aircraft a second time. This time blowing down the mechanics ladder, spreading tools and loose items further from the Air Attack aircraft. At this point the helicopter turned into the parking/ramp area and passed the Air Attack aircraft on the opposite side, passing between a hanger and the Air Attack aircraft, again knocking down the mechanics ladder, blowing tools around and spreading loose items as far away as the runway. CORRECTIVE ACTIONS: Acting RASM Comments: FAO discussed the occurrence with both parties involved and resolved this issue at the local level. Great professionalism by the FAO to bring those involved together to discuss the event and future preventative actions. FAO discussed situational awareness, aircraft separation considerations (related to prop & rotor wash), and the importance of good communication.

SAFECOM 11-396: Evasive action taken between two aircraft in the Wallow TFR at the same altitude on intercept headings. Aerial operations on the Wallow Fire involve three T1 IMT's operating in three zones under one 30NM radius mega TFR. Area command was provided an aircraft to facilitate travel between distant areas of the three zones for critical information exchange (alternate ground transport round trip times estimated at 8-10 hours). A large map of the virtual fences of the TFR was used to brief the pilot, but no small maps for the cockpit were available. Instructions were to work with the air attacks of the zones through which transit was required on the TFR/coordination frequency. Area Command (AC) aircraft departed Reserve, NM enroute Show Low, AZ and attempted to contacted Zone-2 air attack to get clearance through the Zone-2 portion of the TFR. After attempting and failing to contact air attack on the Wallow TFR/coordination frequency, contact was made on the Zone-2 F/W frequency and they were cleared for transit through Zone-2. They approached and crossed the virtual fence from Zone-2 to Zone-1 more quickly than anticipated without making contact with Zone 1. They spotted another aircraft, which was the zone 1 incoming relief air attack (AA) at less than ½ mile distance at the same altitude directly ahead—turning away. They made a right turn to continue increasing separation. Zone 1 relief AA then contacted Zone 1 AA to ascertain what other aircraft were in the TFR…AA stated that there was no known traffic in the vicinity, and he did not know who it was. Zone-1 AA then contacted Zone-2 AA which informed him that AC aircraft was on a flight from Reserve to Show Low. AA then contacted Zone-2 AA to confirm the clearance that was given to AC aircraft. CORRECTIVE ACTIONS: Pilot maps of the general fire area with the TFR boundary, virtual fences, and frequency assignments are now available for all aircrews to better facilitate any transits across the mega TFR. Briefings have been conducted with all flight crews and aviation overhead regarding the issues and concerns raised by this incident. Area Command facilitated additional discussion with IMT AOBD’s and Forest Aviation to develop a new plan for operations within the mega TFR that is feasible given the number of VHF-AM frequencies that can be effectively monitored by incident aircraft. All TFR transit flights for point to point aerial transport have been halted—such non-tactical, non-time critical transport missions will travel around the TFR to destination, contacting the appropriate air attack on their respective frequency prior to TFR entry, and/or on lift off from airstrips within the TFR. RASM comments: Here was our fifth “close call” this season. We need to be ensuring communication is in place and aircraft know the locations of other aircraft working (or transitioning through) in the area. Good mitigations on the part of the fire. Removing non-tactical missions from the TFR will help.
SAFECOM 11-348: Helicopter departed for a PSD mission that involved burning out around a mobile repeater site with our pilot, firing boss/aerial ignition specialist (FB) and the PSD operator/helicopter manager. Our flight profile was initially delayed as we sized up a new spot fire to the north. After the size up, helicopter continued to the repeater site and performed the aerial ignition mission. As we let the fire establish itself around the site, we decided to move west to another section of the fire to recon an area where ground crews were going to burn out around several structures. We were on scene for approximately 35 minutes when we decided to head back towards the repeater site. We decided to fly under the smoke column to see how far the fire was down the slope along the road. We followed the road for about a mile at 125-150 feet above the trees and about 40 knots of forward air speed before our pilot stated that he was going to turn around because of the visibility. As we initiated the right hand turn, we could feel the aircraft settle and drop in altitude nearly 30 feet. As the pilot nosed over the aircraft and pulled power to get into forward flight, the ship gained maybe 5 feet in altitude and we sharply spun to the right. We completed 3 full spins before the pilot was able to regain full control and pull forward into fresh air. The PSD operator/helicopter manager was the only passenger to assume a crash position and put a ball bag for the PSD in front of him to help prevent any injuries in case of a hard landing. The PSD operator/manager was also about to initiate a "MAYDAY" call during the third spin but felt the ship move forward and a call was never initiated. As we flew forward, we noticed that we were approximately 50 feet above the trees and we had lost around half of our altitude we had before the turn. An instrument warning light went on during the circles and was checked after gaining altitude and the pilot stated that everything was within normal limits and there was no 'over-torque.' The crew had a discussion within the cabin about whether or not to continue to fly, set down as soon as possible, or return to helibase. All parties concluded that everyone was ok and that there were no mechanical problems and everyone agreed to continue flying. We stayed on scene where crews were burning out that had poor lookouts, one escape route, and limited options for another 15 or 20 minutes with the plan in place that if anyone felt uncomfortable again, the winds got too much, or if there was any kind of mechanical issues discovered, we would head back. Also we gained significant altitude for all operations and had several options for a way out if it was needed. After determining the crews were going to burnout and follow their escape route out, we departed the fire for the helibase.

CORRECTIVE ACTIONS: An AAR was held at the helibase with both helicopter crews, pilots, and the helibase manager. Three notes were quickly noted about this incident. First, the pilot, should be recognized for his outstanding training and skill during a potentially hazardous spin that occurred from what we believe was a gust of swirling wind that lead to the loss of tail rotor effectiveness {LTE}. Second, that sticking to the mission at hand reduces the risk and exposure. We initially began the mission as an aerial ignition platform with a PSD machine, but continued to operate with a recon flight after finishing that mission. This is a standard process because of the lengthy timeline of PSD operations. We often perform a recon as we wait for the fire to come together. On this occasion we had another type 3 that could have been used. I also recommend an additional line for the PSD Go-No Go Checklist which we employed the very next day during a PSD operation. Federal policy is to put a firing boss/aerial ignition specialist in the front seat during these flight profiles, however, these people often have limited experience compared to helitack folks with emergency procedures. Also we often put crewmembers in as PSD operators that have limited experience. My recommendation is to go over the emergency procedures with the FB and ensure that they know their assignment and responsibility in case of an emergency. In our situation, the FB did not say anything during the spins. Additionally, the PSD operator has to protect themselves as much as possible with the PSD machine directly in front of them. The most appropriate person to establish the “MAYDAY” call is the FB and they should be briefed for that responsibility. The regional aviation safety manager sent a member of their team down the day after the incident to discuss LTE & performance charts. RASM comments: we were lucky. Kudos to the pilot and helicopter manager for such a great write-up. I am re-sending the Safety Alert dealing with Flying in mountainous terrain and info on LTE to brief your folks on. The decision to continue the flight might not have been the most conservative. Taking a break to catch your breath and fully relax after such an intense event seems like a lower risk than continuing to fly.
SAFECOM 11-446: An Exclusive Use Helicopter was assigned a two part fire communication repeater mission involving a helicopter manager and two communication technicians. The first part of the mission involved the switching of batteries on a previously set repeater. The communication technicians performed the battery change and three packaged sets of expired batteries were removed. The helicopter manager placed the expired batteries on the left side cargo compartment, side by side next to a new repeater box. The second part of the mission involved the same personnel who were installing the new repeater at another location. After landing at the next repeater site, the helicopter manager unloaded the communication technicians and the repeater box from the cargo compartment. While unloading the cargo, the helicopter manager placed one of the expired battery packages on top of the other expired packages in the cargo compartment, closed the cargo door, and proceeded back to the helibase. No additional items were in the cargo compartment. Upon landing and shutting down at the helibase, the cargo door was opened by a helitack crew-member that observed smoke emanating from the battery packages. No fire was reported and the battery packages were removed from the ship. Upon further investigation it was discovered that the battery terminals were not protected and had melted the plastic carrying handles. No damage occurred to the helicopter cargo compartment. See attached photograph. CORRECTIVE ACTIONS: After consulting with the communication technicians, it was determined that all batteries from the repeater boxes expired or not, should have the terminals covered by either the safety caps, taped, or placed in the original boxes, and not stacked when the positive terminal could possibly make contact with any other metal objects. RASM comments: Thanks for sharing your lesson learned. Hazardous materials need to be handled with special attention. Great reminder to treat "dead or expired" batteries with the same caution as fully powered live ones. After consulting with the communication technicians, it was determined that all batteries from the repeater boxes expired or not, should have the terminals covered by either the safety caps, taped, or placed in the original boxes, and not stacked when the positive terminal could possibly make contact with any other metal objects. RASM comments: Thanks for sharing your lesson learned. Hazardous materials need to be handled with special attention. Great reminder to treat "dead or expired" batteries with the same caution as fully powered live ones.

SAFECOM 11-450: During Recon of fire perimeter, Ops Section chief in front left seat was flying recon mission approx. 1000 agl. and attempted to adjust his seating position to look at target underneath aircraft, to do so he pushed his right hand in center of seat and the left hand attempted to use collective cover to maintain balance, not noticing that the collective cover had blown off some point during flight, left hand hit collective attachment point, thus causing aircraft to descend unexpectedly. Pilot recovered aircraft immediately, accessed cause of rapid decent, and then continued mission without mishap. CORRECTIVE ACTIONS: Avoid using collective covering as a balance point. New covering on order. RASM- This is a common occurrence when controls are not protected with approved covers. It’s a good idea to brief passengers on the location of controls and the possibility of interference.

SAFECOM 11-521: While flying ATGS over the Fire, right piston engine blew. The prop stopped turning, the pilot followed proper emergency procedures and landed safely at airport 20 miles away. CORRECTIVE ACTIONS: Replaced airplane and went back to the fire. RASM comments: Glad the pilot was able to land safely. Notifications on the maintenance side occurred, but the RASM needs to be notified of precautionary and forced landings. The airplane was replaced with another. The engine will be replaced and through the AMIs return to contract availability at some point in the near future.
SAFECOM 11-344: The a/c was taken to Show Low to comply with the recent manufacturers ASB. As part of the return to contract availability an on site physical inspection was completed. The vendor mechanic had maintenance manuals open and was using them. Kudos to the mechanic that may have done the job of removing and reinstalling the rotor head several times in the past but recognizes the importance of following procedure and taking the time to do the little things. **CORRECTIVE ACTIONS:** RASM comments: As the submitter states, kudos for the mechanic to use the manuals to ensure the work was completed to the highest standard. The mechanic’s level of professionalism and commitment to aviation safety is commendable. Thanks for sharing the good work being done out in the field.

SAFECOM 11-379: A heavy air tanker arrived at the airtanker base to support the Wallow Fire. This arrival marked the first usage of this specific airtanker at the ATB. After its first mission, the tanker returned for a load and return. Tanker base ramp personnel were in place to both park and wing-walk for the tanker. After the parking tender stopped the tanker in the pit he signaled the tanker to request permission to place the chocks. A misunderstanding of this protocol to ask permission to set the chocks occurred in which the flight crew understood that the parking tender was signaling that the chocks were already set. The Ramp Manager and a second parking tender, driving a golf cart, and an airport employee driving an air stairs vehicle approached the tanker to set the chocks and secure the stairs. As they approached, the tanker began rolling forward. The air stairs driver immediately responded by backing the vehicle up, as did the ramp manager and second parking tender. The initial parking tender, using a radio, instructed the tanker to set the brakes. The air crew responded and stopped the tanker after a 40 foot roll forward. Chocks were then set in place and a debrief between the air crew and base personnel occurred. During this review, it was determined that the standard tanker base ramp protocol differed from that of the protocol followed by the air crew. It was also determined that the simultaneous release of the brakes and engine shut-down allowed the aircraft to move forward. **CORRECTIVE ACTIONS:** All parties involved discussed what had occurred and the reasons for it. It was decided that hand signals given by ramp personnel would be followed up with radio traffic conveying the same information. Ramp personnel will not ask permission to set the chocks, understanding that as soon as the ‘brakes set’ signal is given by the air crew they are clear to set the chocks. Ramp personnel will inform the crew once chocks are set. Also, the air crew will not release the brake until the engines are throttled down. RASM comments: There was good follow through by the local forest and airtanker base. This was a new airtanker for the airtanker base, and protocols and procedures needed to be talked about. The event occurred before that discussion could happen. The airtanker base personnel are also documenting operational procedures to help others when working with this airtanker. Kudos for spreading the word. No further action required.

SAFECOM 11-336: After take off from SVC Grant County the tachometer for the right engine stopped working. It had functioned properly at the run up prior to take off. Engine seemed to operating properly and flight was continued. **CORRECTIVE ACTIONS:** Reported problem on landing and problem was fixed. It was determined the tach generator on the right engine had quit, it was replaced and after calibrating and run-up everything was ok. RASM comments: The tachometer is not able to be deferred based on the MEL. Once it became inoperative, the flight should have terminated and the aircraft returned to the airport. Communication with the AMI would have let the ATGS understand the process, but it did not occur. After the repairs were made, the vendor mechanics checked with the AMI and the aircraft was returned to contract availability. Communication with SMEs {such as HOS, FWOS and AMI} needs to occur, so we all can work together and operate at the lowest practicable risk.
SAFECOM 11-516: We were making water drops on the fire in division P supporting a burnout operation. Water was being drawn from a Reservoir. Turn times were averaging about 16 minutes and we were working with one other Helitanker. Drops were different every time we went in and we were passed to different ground contacts for directions to the drops to meet their needs. On this particular drop I was passed off to a contact who wanted water dropped on a flaming tree in the bottom of Oversight Canyon. It was a bit difficult to locate the tree as there were a few trees that appeared to be smoking. I was on my second drop to this same tree. The first time it was burning and easily seen. This time it was not so easily seen. Before I dropped I wanted to be certain that I was on the right tree since there were people down in the draw working the burn. As a result I made about 4 passes to verify the tree. I was able to come down the west side of Oversight Canyon clear of the drifting smoke and able to line up on the verified target which was clear of personnel. I was splitting my load since I felt a burning tree did not require a full load of water in one drop. There did not seem to be any abnormal or rough turbulence that caused me any concern. Weather observations, reports and comparisons to other days that we have flown should give a good picture for the wind conditions. I came down the canyon for the drop and made normal corrections during the approach for the smoke and air movement, keeping forward air speed and a safe altitude to avoid downwash on the fire. I felt that I was about 200' AGL (about the height of a 200’ long line) on my approach to a 100’ high pine tree that I was dropping on. It seems that within 1 second or less after the drop that we heard a bang as the right chin bubble broke in. It was at the drop time or immediately thereafter, but not before. We saw nothing. There was just a bang, and now a broken bubble. Both the copilot and I were concentrating on the drop and had no clue as to what happened. My first thought was that I did not get the cargo door latched and that it flipped up in the wind and took out the bubble. I dumped the second half of my load out on a clear hill side, headed for helibase and reported to air attack that I was inbound to helibase. **CORRECTIVE ACTIONS:** HMGB comments: At 1515 the aircraft arrived back at helibase and the damage was inspected, documented, and photographed. Initial statements were gathered about the incident. Appropriate regional and national contacts were made. On 6-25-11, an ASTAT team arrived and conducted their investigation. Approvals for vendor to conduct aircraft repairs were given and repairs began on 6-26-11. Maintenance inspector notified and return to contract availability given. Logbook entries sent. Additional information and corrective actions to follow from ASTAT team. RASM comments: In investigating this event, it was determined that the damage was caused by the snorkel. The inputs to set up on the drop combined with the sudden release of weight on the aircraft at the time of drop and the flexibility of the snorkel hose all lined up to ‘‘fling’’ if you will the snorkel head into the chin bubble. This event was classified as an Incident with Potential. Expect more information to come out as the report is finalized.
SAFECOM 11-486: TFR intrusion. Helicopter entered the Wallow TFR and landed at Springerville airport without any contact on the TFR frequency. Showlow Dispatch picked him up flying towards the TFR on AFF and attempted to contact him on both air guard and national flight following with no response. Showlow then contacted the helibase as the aircraft was landing. Helicopter did announce his arrival on CTAF. The helibase trailer was able to monitor him as he came in. There was no fire traffic in the area when he arrived. According to the pilot, he was flying from Phoenix to West Texas and was making a fuel stop. **CORRECTIVE ACTIONS:** The helibase manager and deck coordinator contacted the pilot face to face and explained his TFR intrusion. They then briefed the pilot on the TFR area, TFR frequencies and the route they would like him to fly out of the TFR area to avoid flying through any other active zone of the fire. They also provided the pilot with national flight following frequency and tone guard to ensure the pilot had the basic frequencies he needed in case a dispatch center needed to contact him in flight. Pilot complied with instructions and exited the TFR as requested. He contacted helibase on TFR frequency and followed the TFR protocol explained to him when leaving the area. RASM comments: Good follow through in giving the pilot the information he should have had. Aircraft can still go into TFRs for airport ingress and egress for an airport located within the TFR, although radio contact through the TFR frequency is expected. A well written and distributed NOTAM is only good if pilots take the time to check them. Here is another example where see and avoid is king.

SAFECOM 11-369: We were requested by the Sherriff’s Dept. to search for possible arson suspect in the vicinity of the Hill fire appr. Prior to leaving we got the call sign of the Huey we thought might be working the fire. After leaving the airport we attempted contact on 123.025 as well as tower freq. with no success. Approaching the area we saw the Huey doing bucket drops in the heel area of the fire so we remained in a low orbit around a hill top appr. 2mi S/W of the area. Additionally we saw what appeared to be air attack overhead so we also tried to contact them on 123.025 as well as guard, 168.625 with no response. We heard the Huey contact the tower and asked tower to ask him to come up on 123.025 so we could coordinate our mission. He responded to the tower but we got negative response on 123.025. About this time we saw Air Tankers arriving in the area and continued our orbits out of the area as well as our attempts to contact Air Attack. On our last pass we saw Air Attack as well as the tankers headed our direction so we descended even lower and landed at a gravel pit at the base of the hill top. It was at this time that the Huey came up on tower and said that the tankers had to abort and we should leave the area. This was very frustrating as air attack should have been aware of our presence from the start and it would have been simple for him to contact us on either the tower freq. or 123.025. prior to the arrival of the tankers. We had locations of the suspects as they were being pursued on the ground and were unable to respond. **CORRECTIVE ACTIONS:** We departed the area. RASM comments: Follow up is occurring.
SAFECOM 11-419: A Single Engine Air Tanker {SEAT}, was returning from the Duckett Fire after dropping fire retardant for Division Bravo. The pilot stated that approximately 12 miles out from the Airport he monitored the airport’s Automated Weather Observation System {AWOS} to receive the current weather information. The pilot approached the airport from the Northwest to enter a downwind to Runway 11. On the final approach the pilot noticed a large “dust devil” {Thermal} crossing the runway and the pilot decided to abort the landing and continue flying the runway heading. The pilot decides, based on the visual confirmation of the airport wind indicators, and prior knowledge of the runway, to land on Runway 17. The pilot enters left downwind, base and final for 17. The pilot elects to fly a high observation pass of R17 to check wind conditions. The pilot was satisfied with the quartering prevailing wind from the West, South-West {AWOS} and elected to land R17. The pilot entered a closed left traffic pattern for R17 and at the approach end of R17, just after the runway threshold, the pilot encountered a “wind shear” and dropped approximately 80 to 100 feet. The pilot arrested the sink rate by applying engine power, landing approximately 200’ from the approach end of the runway. The pilot continued on R17 and just after crossing taxiway A1, encountered a left wind shear, applied rudder, brake and power to get more air over the wing for additional directional control. The pilot then applied full take off power. The aircraft continued right of runway center and went off runway. The right tire contacted a small berm forcing the aircraft to bank left. The aircraft continued on it’s heading, gaining airspeed to become airborne when the left leading edge of the wing contacted a runway marker, breaking off the marker and damaging the leading edge, lower wing skin and left aileron. The left wing tip contacted the ground but was undamaged except for scratches. The pilot was able to get the aircraft airborne and banked left for a landing on Runway 29. The pilot landed uneventfully on R29 and taxied back to the Airtanker base. The pilot was uninjured by the incident. CORRECTIVE ACTIONS: RASM the NTSB has reviewed the damage to the aircraft and has classified this as an incident. The USFS was determined to have operational control of the aircraft at the time of the incident and coordinated an Interagency effort to investigate the incident. That investigation is still underway, but for learning purposes, points of the incident are being documented in this SAFECOM. Weather observations recorded at the airport {SAI AWOS/ASOS} during the 10 minute period in which the aircraft attempted to land showed average wind speeds 14-21 mph and gusts of 40 mph. Winds were variable as recorded at time intervals 1:16 pm equals 150 v 210, 1:17-1:18 pm equals 190 v 280 and 1:25 pm equals 210 v 270 degrees. Visibility was 10 miles and clear. {SAI AWOS/ASOS} recordings prior to 1:16 pm and after 1:27 pm show consistent and steady winds 6-18 mph and with gusts 15-23 mph. This hazard is currently not documented in the “Aviation Risk Management Handbook” System - SEAT, Sub system – environment, Hazard – wind shear on landing, causing the pilot to lose control of the aircraft resulting in an incident or accident. Mitigation – abort landing and hold at a safe altitude and location while monitoring for conditions to improve. Divert to an airport with more favorable conditions.