SAFECOM’s by Aircraft Type

For the month of June there were 82 USFS SAFECOM’s submitted, slightly below the 10 year average of 90. Of the 82 SAFECOM’s reported, 19 were airplane, 2 SEAT, 11 airtanker, 47 helicopter and 3 N/A. The chart below shows the percentage of SAFECOM’s by aircraft type.

SAFECOM’s by Category

There are generally more than one category assigned to each SAFECOM, resulting in a grand total of more than the total number of SAFECOM’s. There were 5 airspace, 31 hazard, 21 incident, 37 maintenance related and 5 mishap prevention SAFECOM’s reported for this period. Below is the percent of SAFECOM’s in each category.
SAFECOM’s by Category continued...

AIRSPACE - There were 5 airspace events reported. Of the airspace events, 3 were conflicts, 2 intrusions and 1 route deviation. A couple instances were: Aircraft dispatched from adjoining unit entered airspace without communicating with controlling dispatch center or air and ground resources. A private aircraft landed at a closed airport that was being utilized as a helibase causing great concern for a helicopter fueling near the runway.

HAZARD - There were 32 hazard reports. Communication issues were the most reported, with issues ranging from base radios going out, aircraft radio issues, ground and pilot communications, and ramp communications associated with making assumptions. The next most reported issue was pre-flight action in which most were regarding doors that were not properly closed and one instance of the chalks not being removed.

INCIDENT - There were 22 incident reports. The most reported was dragged loads, all having to do with buckets hitting trees or snags. Good communications between the pilot and ground resources are essential to ensure helicopters and external loads including buckets are clear of all hazards. Dropped loads were the second most reported, all were with helicopters. There was one injury to a firefighter that was hit by a type 1 helicopter water drop.

MAINTENANCE - There were 36 reports submitted having issues associated with maintenance. Engine and avionics issues were the most reported with 6 reports each followed by electrical and mission equipment with 4 reports each.

MISHAP PREVENTION - There were 5 SAFECOM’s in this category which included 2 instances where pilots made outstanding decisions, one with a maintenance deficiency and another due to weather conditions. There were two events where parking tenders noticed issues with aircraft and stopped the mission. The other noted the professionalism on error detection and correction during rappel training. Nice work folks ~ THANKS

Excerpts from Chief Tidwell’s Safety Message of 7/02/13:

“The 2013 fire season is well underway and is likely to continue at a high intensity level for several more months. I encourage all employees to pause in their work day and think about the following questions that originated from the five (5) practices of our agency Safety Journey:

♦ How confident are we that the proposed work is worth the risk?
♦ How do we do this work safely?
♦ How safe am I now?
♦ What are we learning?
♦ We ask that all fire managers, fire personnel, and all employees take the time to thoughtfully engage in discussion. We thank all firefighters and support personnel for all their efforts, and ask for a constant focus on managing risk appropriately.”
SAFECOM’s

These are samplings from the SAFECOM’s submitted for the month of June. We hope you will discuss the lessons learned in your daily briefings. Some of the SAFECOMs have been edited due to length, to read the SAFECOM in its entirety, please click on the link.

SAFECOM 372: A type one helicopter working with a hand crew dropped water approximately 400 feet down a very steep slope from actual identified target. A crew member was hit by the water drop, fell and rolled over and then slid down slope. Other crew members got wet but sustained no injuries. The one injured crew person was transported to a local hospital and released. Neither Air Attack nor helibase were notified of mechanism of injury i.e. (Aircraft involved). Pilots on scene were unaware of any incident until aviation management (AOBD) notified helibase staff. Pilots were interviewed about the assignment the next day and stated `communications weren`t good. `Pilots also stated `it was a tight spot for 2 type ones”. CORRECTIVE ACTION: FAO/ATGS: This WAS a tight area for the quantity of and type of aircraft we had working in the area. The crews were briefed after the incident on the need to ensure all crew members evacuate the drop area and that when operating on steep ground that they must move further as their actual distance from the aircraft is not as far as would be expected when moving away on flat ground. Also the AOBD was reminded by the ATGS`s that the heli-tankers may not be the best tool for the close in support that was being asked for by the crews. RASM: An AAR was conducted and the above mitigation`s were put in place to prevent this type of event from happening again. Good learning opportunity, crews must go a further distance when on steep terrain when working with helicopters and if the pilots feel it is a tight area they need to speak up.

SAFECOM 343: A helicopter was dispatched for a water dropping mission. After the helicopter departed, direction was being provided by the Air Attack (AA) for target identification. Upon identification of the first target, the pilot called back to AA confirming the target when the push to talk (PTT) switch on the co-pilots cyclic became stuck in the `open` position. From this point on the pilot could not receive any transmissions nor conclude that his transmissions were heard as he did no know if the problem was isolated to the PTT switch. CORRECTIVE ACTION: The pilot immediately notified AA with a `call in the blind` of his situation and cleared the area, dropped his water, and gained elevation outside the fire perimeter to perform some minor troubleshooting. With a determination that the PTT switch was just not stuck, the pilot proceeded to return to the helispot. The pilot continued switching between AUX and the victor (as not to jam up operational frequencies) for position call outs and visual contact of other aircraft. Remaining in a higher altitude pattern, the pilot arrived at the helispot and saw HECM(s) staffing a pad and marshaling. He landed without incident. The vendor mechanic and the HMGB drove to the helispot from helibase and initiated maintenance. The IHOG provides reference to return to departure base or facility where check in can be made. I commend the pilot for his quick and prudent thought process and actions taken. FAO & RASM-Good job by pilot to mitigate possible conflicts by modifying flight path and returning to base, also understanding the possible conflicts that could occur with other radio users while his radio was locked up. The pilot did everything right to ensure a safe landing and possible airspace conflicts.

SAFECOM 13-447: A five person module was responding to a smoke report on the district. While observing the smoke they noticed a SEAT flying around the smoke. The Deadman Lookout also noticed the SEAT and contacted Dispatch asking about it. The 5 person module had no luck in contacting the SEAT on any frequencies. While the module prepared to hike in, the lookout observed the SEAT dropping a load of blue retardant and notified dispatch. The local helicopter was requested however it was not launched due to the unidentified SEAT. When the module reached the fire it was confirmed that the SEAT had dropped on the fire without making radio contact with any ground resources; and dispatch had no knowledge of the SEAT. CORRECTIVE ACTION: The dispatch center was contacted to investigate and it was determined that the SEAT was launched by an adjoining agency with no coordination with neighboring dispatch center. RASM comments: Follow up is occurring. There are three issues here. The first two are focused on communication - launching an aircraft without a request and aircraft dropping {water or retardant} without contact to the ground crews. Dropping without communicating can have serious and injurious effects for those on the ground. If a pilot does not have communication with folks on the fire, they should not drop. The third hazard is the airspace conflict between the SEAT and the helicopter. Fortunately, folks identified this risk and the helicopter was held to avoid the airspace conflict. Thanks for sharing to remind us how important communication is and how to reduce risk.
SAFECOM 13-426: While coming in to land after a maintenance test flight, the gear handle would not move from the up to the down position. We left the traffic pattern to sort out the problem. I noticed that the clasp on the gear handle (that must be pinched toward the gear handle to move the handle up and down) was loose, indicating a problem inside the gear handle assembly. I got a pocket knife out of my purse to try to move what the clasp normally would have. After about five minutes, we were able to move the gear handle to the down position. The gear came down normally and we landed without incident. On takeoff, the only indication that we might encounter a problem later was that upon gear retraction after takeoff, the gear handle did not move smoothly up but felt sticky. **CORRECTIVE ACTION:** The aircraft was repaired and returned to availability. RASM Comment: When the aircraft went into maintenance it was discovered that there was a small broken spring in the gear handle clasp. Using the pocket knife to free the clasp pushed the broken section of the spring away from the clasp allowing the handle to be moved. I don’t own a pocket knife: I wonder what I would have done? Great job pilots!

SAFECOM 13-420: The helicopter was performing bucket drops on a remote section of the fire. The aircraft was equipped with a 240 gallon bucket and 150' synthetic longline. The pilot had made several drops in the same area without incident. During a bucket drop near the end of the fuel cycle the pilot entered the drop area to cool down some heavy ground fuels with a ponderosa overstory. As stated by the pilot, the ponderosa pine flared up just prior to release of the water and briefly contacted the bucket and longline. The bucket was approximately fifty feet above the highest trees at the time of the flare up. The pilot successfully released the water and returned to the helibase without further incident and brieflyed the helicopter manager on the incident. Upon shut down of the aircraft the pilot and mechanic inspected the bucket and longline and found only minor heat damage to the protected sheath covering the synthetic longline. No damage was sustained by the bucket or longline. The aircraft resumed bucket work without further issues. **CORRECTIVE ACTION:** The pilot was proactive in notifying the Helicopter Manager and returning to the helibase for a damage inspection. After inspection the aircraft fueled and returned to the area for additional bucket drops. Rotor wash may have been a contributing factor in the increased fire activity however dropping from a greater height would not have been effective. RASM comments: The pilot did a great job reacting to the unexpected situation and in deciding to return to helibase and check things out. Flare ups can unexpectedly occur during firefighting for several reasons. We need to continually assess risk, mitigate when possible and react accordingly. No further action required.

SAFECOM 373: Helicopter XXX was dispatched to the Fire for bucket work and established communication with ground contact in DIV A. After 5 bucket drops, all of which the ground contact reported to be at an altitude of around 75 feet above the tree tops. Ground crews requested lower water release on each turn, and the pilot set up 25 to 50 feet lower for drop number six. Just as he approached the intended target, the pilot could tell the bucket was on a collision course with a taller tree in the area. The pilot attributes the collision course to a change in wind speed and direction as well as possible downward moving air. He immediately released the water load to gain altitude and zeroed forward air speed in case of a hang up. The bucket grazed the top of the tree and slowly rolled to the side, swinging free. The pilot returned to the dip site, tested the bucket, and found it to be operable. He then continued bucket operations and performed 18 drops without incident. Upon completion of the fuel cycle, the ground contact who observed the bucket make contact with the tree, requested another fuel cycle. After a ground inspection of the bucket at helibase, the helicopter returned to the same location and performed 25 drops without incident. **CORRECTIVE ACTION:** Pilot and manager discussed the need to maintain adequate drop heights regardless of ground contacts requests and to stop operations if wind conditions are not favorable for bucket operations. All water drops following the incident, were made from a higher altitude. FAO- Corrective action spot on. RASM- AOBD on fire contacted to brief ground entities on effective reduction in margin for error when requesting aircraft drop from lower altitudes. If drops being made are not tactically effective and lower altitudes are not possible, consideration should be given to stopping bucket operations. The same information was also relayed to the air crew in this instance. Good corrective actions as mentioned that should translate to proactive risk management decisions. RASM Update - 7/08/2013 R2 HIP was able to make contact with the pilot to discuss the event and give some training with respect to avoiding this type of incident in the future. Additionally data is being collected to take a closer loop at aircraft performance to ensure the right aircraft is utilized for the demands of the mission.
SAFEicom’s continued......

SAFEicom 353: While delivering buckets to the West Fork complex, smoke conditions and low sun angle contributed to lessened visibility. Due to high winds, the pilot was dropping at a low altitude to ensure that the water would hit the intended targets. Standing dead snags were gray in color and difficult to distinguish in the increased smoke and decreased light. On the third to last bucket drop, the bucket struck the top of a snag and the pilot released the water. The water released from the bucket broke the top out of another snag. Ground personnel notified the pilot that his bucket had struck the tree and the pilot made remaining drops at a higher altitude with no further problems. CORRECTIVE ACTION: FAO: Had discussion with HMGB, he had talked to his pilot and discussed the added risk of vertical reference missions in low visibility conditions, and PIC discretion on when to dis-engage.

SAFEicom 317: An un-forecasted hail storm came through helibase from approximately 1310-1350 hrs. HEB2 and ABRO had been monitoring weather radar and saw predicted moderate rain, but no hail prediction. Additionally, the day’s Fire Weather Forecast in the IAP as prepared by the Incident Meteorologist did not include any potential threat of hail but did include a 40% chance of wetting rain. All aircraft were parked on the ground at helibase. We began initial damage assessment as quickly as possible following storm passage. Initial aircraft assessment for the Type 1 aircraft revealed superficial damage (dents/pock marks) on the horizontal stabilizer surfaces, forward tail section, and upper blade surface near the servo flap. In addition to the aircraft, damage was sustained by the Type 1 contractor’s support trailer. The plastic vents on top of the trailer were shattered by the hail. Initial aircraft assessment for the Type 2 aircraft revealed broken windows above the pilot seat. Initial aircraft assessment for the Type 3 aircraft revealed superficial damage (dents/pock marks) on the tail rotor drive shaft cover and horizontal stabilizers. The Incident Helibase Manager notified the IC, Regional AMI, and National HOS. The HEB2 suggested that all HMGBs make contact with their specific aircraft contract Contracting Officers. CORRECTIVE ACTION: Documentation was prepared and collected. Pilots/Mechanics made notifications to their company officers. The second aircraft assessment for the Type 1 revealed one particle separator swirl vane was also damaged. A&P replaced the swirl vane. No damage found affecting airworthiness. A&P approved the aircraft for return to service. HMGB placed phone call to AMI for return to contract availability. The second aircraft assessment for the Type 2 on the morning after the hail event, revealed multiple pock marks on the rotor blade surface. A&P is determining if the damage falls within published specifications. The second aircraft assessment for the Type 3 on the morning after the hail event, revealed no additional damage. All damage found is within published specifications. A&P certified the aircraft to be airworthy and approved the aircraft for return to service. AMI was notified and concurred. Present and future severe weather planning includes pre-planning of multiple weather “escape routes”/flight plans to avoid potential severe weather hazards. This was briefed to helibase personnel. RASM Comments: Weather can be unpredictable this time of year. The helibase experienced quarter-sized hail stones that were not expected. Great response by the helibase in communicating the event with the respective COs and the Regional AMI. Good risk decisions to conduct thorough inspections before flying. This is a good reminder to be conservative and if possible move aircraft to avoid storms. See Regional Lessons Learned document.

SAFEicom 292: During a backhaul mission, I requested the helicopter place the load of back haul on an “X” made of orange panel, then place the remote hook next to a load of cargo which was daisy chained with two nets. After the load was on the ground he set his hook next to the back haul approximately 15-20 feet away from the outgoing cargo. I announced to pilot “Hook is on the ground sending in hitcher”. Hitcher was half ways to the load when the pilot lifted hook off ground and placed it closer to the load. Hitcher stopped and waited for hook to be placed back on ground then proceeded to load. As she attached the load to the hook, the pilot began to lift causing the longline to rise off the ground rubbing against the left side of her body and bringing the cargo hook up to her waist. She immediately began leaving the area, and was only about 5-10 feet away from the cargo when the first net was lifted off the ground. It began swinging in the air as she left. All of this occurred before she was clear of the area. I did not give the command “Hitcher clear” until she was more than 30 feet away, due to the circumstances. The aircraft then left the area in route to sling site. CORRECTIVE ACTION: Discussed with helicopter manager, and he relayed to the pilot the procedures and protocols for long line external missions between ground forces and aircraft. RASM Comments: There was good follow up on this event. Thankfully, the hitcher was not hurt. The pilot is fairly new to fire and is working on developing CRM with the crew members. This event highlights the need to discuss operating protocols as each new person becomes involved. With folks rotating through assignments (including vendor personnel) we must remember to take time to establish how we will operate, even for the basics. Thanks for reminding us that instructions need to be clearly understood by all.
SAFECOM 290: Series of events. 1) Base manager assumed manager would brief pilot on base protocols. 2) Pilot and 2 observers leave to get in plane without notifying base personnel. 3) Pilot did not do an adequate walk around aircraft. 4) Pilot starts aircraft without being in communications with base or ramp. 5) Front nose chalk still in place with both props turning, still no radio comm with aircraft. Pilots on ramp and ramp personnel giving pilot hand signals chalks still in place. 6) Qualified base person newly arrived on a detail states I’ll take care of the chalk. Person equips themself with proper PPE and leaves to go on the ramp. Expecting this person to signal the aircraft to shut down to safely remove the chalk. Still no radio comm in place. Ramp person walks directly up to the nose of the King Air with both props turning and maneuvers the chalk clear of the front of the nose wheel. 7) SEAT entering ramp from a training mission request clearance onto base. Clearance denied until we had communication with King Air. Seven events that could have led up to a serious accident. CORRECTIVE ACTION: Base manager (me) needs to insure all base personnel have been properly briefed on ramp protocol. If this had taken place the odds are that events 2 - 7 would not have taken place. To correct this we had a briefing with all party’s involved when the aircraft returned from its recon mission. Reviewed all ramp protocols, 1. notify base of preparing for departure, 2. be in contact with ramp or base before starting aircraft, 3. proper walk around of aircraft for departure, 4. Never, never remove chalks from a light fixed wing aircraft while props are turning. Full shut down is required. Removing chalks from the aircraft while running took all the observing base people by surprise. Even if someone arrives for assignment supposedly fully qualified, you need to take time to go over plans and procedures with them, especially if it involves something out of the ordinary or daily duties. I feel we were lucky. 7 series of events one after the other and no mishap. The key is thorough briefings with all arriving base personnel no mater who they are. I messed up. RASM: Operational tempo is bound to increase over the coming weeks. This SAFECOM represents the dangers all of us face, we make assumptions, we fail to communicate effectively but above all else we learn from our ‘close calls’ the holes in the swiss cheese if you will. Please take time to review this SAFECOM and apply it to a ‘healthy preoccupation with failure’ so that you don’t have a series events. Thank you for the submission and the lesson!

SAFECOM 280: While taxing out to the runway, the FWPT noticed a small door open on top of the left wing and was unable to make radio or eye contact with the crew. The parking tender’s radio batteries were dying and unable to transmit any traffic, so he had to run out toward the taxiway to flag the plane down. Once the crew noticed the tender signaling them to stop, they returned back to the small aircraft parking and corrected the open door. CORRECTIVE ACTION: Parking tenders need to stay vigilant and watch for things the crews might miss. Also be sure that your radios are able to receive and transmit, low batteries have enough power to receive, but not transmit traffic. The pilot said they will make better inspections being that all three members of the crew missed the door. R5 RASM: Fox Tanker Base personnel have been vigilant and scanning to prevent mishaps from occurring. This is another great example of the airtanker base crew performing well.

SAFECOM 256: FM Technisonics with new software update: When programming a tone into the transmit side only, an up arrow may appear where the decimal in the frequency should be. When pressing the PTT, the tone will not appear nor transmit with. Tx will show instead of Tt. We discovered this issue while programming radios en-route to the fire. I had dispatch call our Director of Ops to have him meet us with a new radio. We immediately replaced the radio upon landing. The replacement radio had the same issue. We continued the flight over the fire using the #2 FM for frequencies that required a tone on the TX side only. Upon taking off for our second shift the #1 radio was fine. CORRECTIVE ACTION: Technisonics (company) was contacted, and after speaking with a technician, he said that this is a normal part of the programming with the new software update and may it be resolved by pressing the escape key. He also said that if you press the escape key again it will reappear. Our radio did not respond to the escape key, but did return to normal after turning the radio off and back on. Only then did it accept the tone and transmit with it. Only the radios installed in the #1 FM spot had this issue when programming a tone. Our #2 FM radio accepted the tone without issue. RASM comments: Technology can both help and hinder our workload in the cockpit. Understanding the nuances is crucial to keeping things helpful. We all know how critical solid communication is to increasing safety. We are working to distribute the information widely, so look for an informational bulletin soon. Thanks so much for sharing your experience. This is exactly what the SAFECOM system is about. See Safety Alert 13-02 Technisonic TDFM-136/A and 136/NV Radio Issues.
SAECOM 247: After dropping off the first of two cargo loads at a sling site, the pilot was informed of bad weather approaching by air attack. Both the pilot and air attack agreed that they had enough time to complete the second cargo load to the sling site. After dropping off the second load, on his way back to the helibase, the pilot was informed by air attack of micro bursts in the area. While watching the long line in the mirror, at that moment the pilot experienced a micro burst downdraft which resulted in the 100 foot synthetic long line bouncing upward towards the tail rotor. The pilot reacted quickly by scanning the surrounding area for a safe place to release the long line, and did so by jettisoning it into the trees. The pilot immediately landed at a helispot close by. CORRECTIVE ACTION: We discussed as a crew that the mission should have been shut down after the first cargo load was delivered, or when the bad weather was approaching. The pilot did the correct action by releasing the long line in a safe place and landing. FAO comments: Hindsight is always 20/20. At least two experienced aviators were watching the weather and they made a judgment that they had time to complete the mission safely. Sometimes the weather does not cooperate with our expectations. In this case when the pilot met the unexpected he reacted and took the best course of action available. RASM Comments: Great airmanship by the pilot, and good risk decision making. The weather moved faster than expected and when faced with a hazard, the pilot chose the lowest risk option- releasing the load and landing to wait out the passing storm. Weather is a huge focus in aviation after the IWP last year. Keep up on predicted weather for the day, watch for telltale indicators of unstable air, such as mammatus clouds and virga {see photos} and stop operations before the storm influences air conditions. Follow up- The long line was recovered and although it looks fine it is being sent back for inspection before use. Another great decision by the vendor. See Interagency Aviation Accident Prevention Bulletin 13-04 - Visibility and Thunderstorms

SAECOM 13-409: Helibase personnel observed a single engine approaching the Mineral Co Airport and landed at the airport. The pilot, he said that he landed due to the weather. At the time the airplane landed, an active thunderstorm was around the airport. The pilot said that he did not know that there was a TFR in effect. He said that he was going to Twin Lakes and that the storm made it necessary to land. The pilot was in violation of the TFR. He parked his plane and decided to wait till the weather became better before he would attempt to leave. CORRECTIVE ACTION: Spoke with the pilot about the TFR, however, the reason that the broke the TFR was due to weather. RASM: When a NOTAM has been issued under {a} {2} - “provide a safe environment for the operation of disaster relief aircraft” no person may operate an aircraft within the designated area unless, and in this case, condition {4} - The operation is conducted directly to or from an airport within the area, or is necessitated by the impracticability of VFR flight above or around the area due to weather, or terrain. Since the airport was not closed the pilot was meeting the TFR requirements.

SAECOM 395: While performing A219 training with local hot shot crew, pilot inadvertently released remote hook while in flight. In preparing to descend he placed his hand on the upper portion of the collective to press down and hit the remote release button. CORRECTIVE ACTION: Pilot discussed the incident with crew and supervisors and feels that the situations that lead to this incident was the placement of the pilots hand on the end of the collective {near the button}, thus inadvertently catching the edge of the button with his gloved hand. In the future pilot will practice keeping hand clear of end of collective area until required to do so per operation. Pilot also discussed with company the possibility of adding a ‘guard’ to the button to help prevent such accidental release from occurring in the future. Company agrees. BDF/FAO: I spoke with the manager, and as it was said in the original text the pilot was covering the top of the collective rather than holding the throttle/grip and inadvertently pressed the release button, pilot did not feel this was his normal method to handle the collective, but obviously did it this time, probably a lesson learned and fortunate not to have damaged anything or injured anyone, pilot and company are also working towards guarding the button {providing a crown around the button} to prevent inadvertent releases. R5 RASM: Good collaboration between crew, company and forest to identify the hazards and put in place the mitigation to prevent further incidents.
SAFECOM 379: Upon landing Colorado Springs after refueling in Gunnison Colorado the line personnel noticed the gas cap was missing. Apparently it was not properly secured after fueling in Gunnison. **CORRECTIVE ACTION:** Aircraft was put out of service. Fuel cap was replaced later that evening. Company A&P made entry in aircraft log book and faxed to RAMI. Aircraft was returned to service the following morning. RASM- Importance of securing fuel cap is understood by all involved. Emphasized CRM and necessity to complete visual inspection/ walk around prior to each departure, paying special attention to any area that has been manipulated while on the ground, which in this case should have been the fuel cap after refueling was completed.

SAFECOM 371: During air tactical operations, the ATGS platform was contacted by a Type 3 helicopter on a recon. mission. ATGS cleared the helicopter in at 6500 and below but advised them that due to air tanker operations on the north end of the fire, coordination needed to occur with the ASM unit on scene to clear them in for recon of that specific area. The helicopter was informed that they should not proceed north of the Granite Dip site. This happened during the initial attack phase of the Fire: ASM was busy talking with Operations on the air to ground frequency. Before the ATGS had the opportunity to contact the ASM, the ASM contacted Air Attack that they had visual on a helicopter in their area of operation which they had not been notified about. ATGS contacted the ASM platform that the helicopter had not been given clearance to enter the airspace where the ASM was working with the heavy air tankers. **CORRECTIVE ACTION:** The ASM established positive communication with the helicopter and established control of the helicopter to recon the north end of the fire. The helicopter acknowledged the error and operations continued as normal. Once the helicopter completed reconnaissance of the north end of the fire, control of the helicopter was transferred back to the Air Attack for the remainder of its recon mission. FAO notes: ATGS followed up with a post flight debrief with the helicopter pilot. RASM comments: This event reminds us to be clear on our instructions, especially when dealing with airspace management. Know who to contact and where the contact point is. The FTA, virtual fences, flight routes and contact points are all mitigation’s to airspace conflicts. We need to ensure we understand and use them correctly. Thanks for reminding us by submitting a report of your experience.

SAFECOM 363: Tanker X was preparing to depart for to fire. In the run up area short of Rwy 21@ with mixtures rich and the recips @ idle, the crew was briefly distracted doing the check list and failed to catch the #1 recip loading up. The crew caught the situation as RPM was below 500. They closed the mixture and opened the throttle but were too late to catch the engine and because of this, the engine flooded and died. The result was a stack fire that was confined to the exhaust system and was visible from the ATB. The crew immediately executed proper procedures to include boost pumps off, mixture to idle cut-off and throttle full open, and cranking the engine. The engine was restarted and the stack fire was blown out. The aircraft taxied back to the base and the crew chief did a visual inspection, revealing no evidence of damage. **CORRECTIVE ACTION:** FAO: Appreciate the honesty of being distracted, good catch and procedures followed to extinguish the fire. Proper corrective action as per Pilot Operating Guide. Good reaction of ATB staff by staffing pit fire extinguishers if engine could not be restarted. ATBM: Also at the first sign of fire Crash Rescue was called and had an ARFS on scene but was not used. RASM- Periods of increased workload in the cockpit aren’t unusual and can lead to distraction. In this case the crew identified the decreasing RPM too late to keep the engine from dying but did a good job responding with immediate execution of proper procedures. Additional kudos to everyone else who responded as expected in this scenario.

SAFECOM 355: While the Helicopter was lifting off at Helibase at a hover 50 feet off the ground the long line fell off the belly hook and fell to the ground. This occurred because the belly hook was not completely closed. The bucket and the control head never lifted off the ground. There was no injury or damage. **CORRECTIVE ACTION:** Manager and the crew briefed on the proper way to hook up a long line and to ensure the required checks are completed. FAO comments: Pilot and crew ran through multiple scenarios trying to replicate the incident. The way the hook is designed it is virtually impossible to have the keeper partially closed. The pilot and crew have set an informal standard by which it will be checked by two people. RASM comments: There could be three reasons why a long line would fall off. One, personnel might not ensure the hook was fully latched after conducting checks. Second, the hook might malfunction. For this, there is a hook testing schedule that falls under the responsibility of the vendor. Third, the pilot might hit the release switch inadvertently. Ensuring the hook latches after conducting checks should become second nature to folks working with helicopters. This is the time of the season that we need to focus on the basics. Don’t get complacent. Remember our training. Fortunately, the line wasn’t damaged or someone injured. Thanks for reporting as a reminder.
Helicopter departed the Helibase at approximately 1830 for a HLCO mission with the pilot, HLCO, and HLCO (T) on board. Maybe 10-15 minutes into their mission when they got diverted to a hiker situation located at the head of the Powerhouse fire. A Type 1 helicopter announced that a hiker needed some immediate help. Once the HLCO helicopter arrived on scene and located the hiker a conversation regarding possible landing areas took place. Meanwhile calls were being made to get LA County Rescue Helicopter dispatched to perform a hoist operation. A type 1 pilot mentioned how congested the airspace became with all the helicopters flying in the immediate area and suggested a counter-clockwise flying pattern. Once a pattern was established it was much easier to navigate and coordinate with the other aircraft. At the helibase, the helicopter managers were called to the ABRO box to discuss a backup plan being short-haul. The possible short-haul mission was accepted and the appropriate pre-planning was discussed amongst the crew. As daylight kept fading and pumpkin time quickly approaching and still no word on whether or not the county ship was coming: a decision to land, grab the individual, and take off for the helibase was made. The HLCO (T) had his concerns because it was unknown if the individual was armed. The HLCO in back was comfortable and said that he would go grab him and load him up. There were no landing zones within the area. The pilot was able to squeeze into a tight bare spot on top of a pinnacle with the HLCO in back guiding his tail rotor. On the ground, HLCO jumped out and hurried to grab the individual approx. 50 yards from the aircraft. If anything looked wrong or did not feel right the Pilot was going to lift immediately and take off. Landing concerns were: 1} there was a weapon and 2} there was enough power capability to hover into land. The aircraft was heavy on fuel since the mission they set off to was interrupted and another person’s weight had to be accounted for. A power check was performed and the pilot felt comfortable landing. Individual was checked for a weapon, then loaded without any PPE and transported to the Helibase. The helicopter had no idea that the ship landed and picked him up, they were still waiting to hear if LA County was coming or if the crew needed to prepare for an operational short-haul. Once in range of the helibase the pilot announced that he picked up the person and he was onboard to prepare for patient care. The crew was ready to receive and care for a possible injured patient. The goal was to keep him going towards the tail rotor as there was a communication barrier because he could only speak Spanish. Once a translator was found he told them he and a friend hiked up the ridge to watch the heavy aircraft drop water and wanted to see the action from a higher point. The fire hit some fine fuel and “an explosion” happened according to the person. The fire chased them off the ridge, the two friends stayed together for a while until at one point one was gone. He said his friend was right behind him once second and gone the next. His friend has not been found. A medical assessment was performed by a paramedic and no injuries or complaints were noted. He was given water and Gatorade to help rehydrate while a ground ambulance was on their way. After the individual was passed off to the ambulance and a sheriff, who finally arrived, a debrief took place. The Pilot mentioned that there were a couple of issues that could have gone better. First they were not told that the county helicopter was not coming. If that was known, the pilot would have encouraged a short-haul operation. Initially there was no flight pattern amongst the helicopters. Everyone kept flying their own path until a pattern was mentioned. There was too many aircraft circling the same area and some should have departed sooner but the heavies were dropping water around the individual. A fire shelter was also tossed out to him from one of the sky cranes. Another issue was a Bravo unit flew into the congested airspace with an air tanker closely behind to drop some retardant to help with the water drops. It was unknown how low he was actually going to get and that through everyone’s flight pattern off for a couple of seconds but was quickly reestablished and no further confusion occurred. A short-haul or hoist operation would have been the safer option rather than landing according to the pilot and others. It would have been preferred not landing but a life was at risk and the head of the fire was not yet close enough to not land. Overall, the mission was successful and another life was saved. CORRECTIVE ACTION: There were a few corrective actions taken to mitigate another similar situation or rescue. First, the whole no PPE issue was the least of everyone’s concern and if there was PPE available the individual would have been given some. Leaving him behind due to no PPE was not an option. Secondly the tight landing area was sorted out due to strong communication between the Pilot and the HLCO in the back. Third an AAR was conducted and several conversations concerning “what if’s” were discussed and two helicopters were designated as primary medevac and secondary medevac ships. Lastly an investigation concerning the communication failure was looked into to prevent anything like this to happen again in the future. R5 RASM: This event was an incident within an incident, the clock was ticking and actions had to be taken, however: nobody responded hastily. All participants in this emergency situation did risk management before they made decisions on what the course of action should be. When a hazard was identified, a mitigation was put in place. Kudos to the Skycrane pilot, who thought out of the box and threw his fire shelter to the civilian.
SAFECOM 13-376: Helicopter XXX was requested to do a repeater mission to fly 2 Comm techs with solar panels up to saddle helispot. The pilots side doors were removed because the aircraft had been doing multiple missions such as bucket work on previous days. The first flight to the helispot had 1 helitack and the radio equipment on board. As the aircraft lifted and started into forward flight a piece of paper flew out of the aircraft. Several people noticed this and pad 5 was the first to call XXX and inform the pilot of what happened, the pilot acknowledged the radio transmission and confirmed what it was. He continued the flight and before his return the helitack crew retrieved the paper. On return for the second flight the helitack crew talked to the pilot and confirmed what happened and we quickly agreed it was safe to continue the flight. After the aircraft returned and shut down, the helitack crew and pilot debriefed on the incident. **CORRECTIVE ACTION:** As we briefed on the incident the pilot stated that the 23’s that we had given him the day prior had been left on his seat. He later returned to the helicopter and noticed that they had fallen into the long line reference window. He took the papers out of the window and put them into his fuel truck. We concluded that two pieces of paper had slipped all the way into the belly pan and had not been realized until they came out during the take off. We looked into the space and confirmed nothing else was in there and confirmed how many papers were in the original bundle and how many we had, so we know that no other papers are missing. We talked about double checking the window and being more careful with what could possibly fall into the window. Talked with HMGB about importance of FOD control. He was well aware and talked of putting paper copies not in the A/C - SJF UAO RASM- Importance of FOD control cannot be overemphasized, especially with the potential of loose items becoming lodged in flight controls. Completing a FOD sweep of the cockpit prior to engine start is a good habit to get into, if it isn’t already included in the pre-flight/pre-start checklists. Good job by all involved in immediate recognition and communication of the situation- a great example of strong CRM.

SAFECOM 13-278: During a training rappel, the spotter had opened the aircraft doors and was guiding the aircraft into the rappel site. In moving about the cabin to open the doors, the red cover snap that is associated with the spotter tether ejector snap came undone. The rookie rappellers got the attention of the Spotter, who was kneeling at the right side door. They tapped him on his shoulder and all 4 pointed to the snap that had come undone. The spotter had the pilot execute a go around-keeping the aircraft within limits. The Spotter reconnected the red cover snap, pointed to the item and then gave a thumbs up to the rappellers. They responded with 4 thumbs up. The Spotter briefed the pilot as to why the go-around was needed, and then set up the aircraft for the rappel site and continued on with the rappel cycle with no further incidents. **CORRECTIVE ACTION:** RASM: No corrective action was suggested by author. Recommend reminding or adding a pre-flight check of the integrity of the red cover snap.