SAFECOMs by Aircraft Type

For the month of July there were 94 USFS SAFECOMs submitted, well below the 10 year average of 202. Of the 94 SAFECOMs; 14 were issues that affected fixed-wing, 7 for airtankers, 70 for helicopters, and 3 were not applicable to aircraft. The not applicable SAFECOMs were related to ground radios and repeaters.

SAFECOMs by Category

There were 2 accidents, 5 airspace, 22 hazard, 20 incident, 45 maintenance, 4 management and 3 mishap prevention SAFECOM’s reported.
SAFECOM’s by Category continued

ACCIDENT - We had two accidents in July, the fatal rappel accident and a SH-3H accident while dipping from a portable dip tank. Both investigations are on-going and no information beyond the initial reports have been completed at this time.

AIRSPACE - There were 5 airspace events reported. Most were TFR intrusions or perceived TFR intrusions. Remember, just because there is a TFR it is not going to keep all other aircraft out. Law enforcement and the media ARE allowed in our TFR’s as well as air traffic in and out of airports. Helibases are not always located within the TFR’s either, or flight paths to and from the incident with a TFR. Don’t let your guard down because there is a TFR, See and Avoid is just as important.

HAZARD - The most reported item in this category was communications (31%), which is below the normal of around 50%. Most of the communication issues were frequency management and ground radios and repeaters. Pilot action accounted for 26% in which most were in association with dragged and dropped loads. Preflight action accounted for 13% in this category. Generally getting mission focused, assuming someone else did or checked something, not using checklists, and distractions cause mistakes prior to flight.

INCIDENT - The most reported in this category were dragged loads, 35% (7 reports) and dropped loads which accounted for 25% (5 reports). Déjà vu! Last year there were 7 dragged and 7 dropped loads, yet much more flying occurring. Please review and brief these Safety Alerts; 2005-01 Helicopter External Load Operations and 2004-08 Clearance from Obstacles during External Load Operations.

MAINTENANCE - Forty-four percent of the reports submitted were maintenance related. Miscellaneous engine issues were the most reported (8) with one engine failure and one engine shutdown. Instrument and electrical problems were the next most reported with six in each category.

MANAGEMENT - Three of the reports were regarding management of resources. The other report was an aircraft flying without an item on the Minimum Equipment List (MEL).

MISHAP PREVENTION - There were three reports of folks doing a great job of preventing mishaps. One was a helicopter manager discovering a bucket set at 90% which was over the allowable, a rappel crew identifying issues with a rope and a mechanic that found a slipping tip cap on a tail rotor during a fuel stop while enroute to an off forest assignment. Great job folks, keep up the good work.

New SAFECOM Feature You can now upload jpeg, gif and pdf files with a SAFECOM report. There are several instances where a picture tells a thousand words, well now you can send them in with your SAFECOM. Please continue to tell the story as well, it certainly is not a replacement for the text information. Make sure the photos are relevant to the SAFECOM and please avoid sending pictures with identifiable information (tail numbers, company names, peoples faces, etc.) Thumbnails of the pictures will be at the bottom of the report, simply click on the picture to enlarge. Please see SAFECOM 09-0307 for an example.
SAFECOM’s

These are samplings from the SAFECOM’s submitted for the month of July. We hope you will pick a couple of them a day to discuss and use the lessons learned in your daily briefing.

**SAFECOM 09-0616** - During a proficiency rappel, ground personnel noticed an object falling from helicopter. Proficiency completed with no issues, after landing ground personnel asked spotter if he saw anything fall from the aircraft, spotter indicated he had not. Ground personnel searched for object and found pedal locking device, which is installed as security for the aircraft. Object apparently fell from flight step, during proficiency rappel. **CORRECTIVE ACTION:** All crew members were briefed on giving the aircraft a complete walk around inspection before flight. **UAO Comments:** Good example of why we carry out pre-flights and “walk around” inspections by both contract flight crews and agency personnel. **RASM Comment:** The more eyes the better!

**SAFECOM 09-0567** - A Type I helicopter tanker was taking off from a helibase located at a local airport. When the helicopter was approximately 100 feet over the deck, a F-18 military type aircraft made a high speed pass by the helicopter while at approximately 500 feet AGL. The military aircraft did not contact civilian personnel/aircraft on scene over published aircraft radio frequencies. No radio contact could be made with the aircraft by base personnel. **CORRECTIVE ACTION:** Prior to the incident helibase personnel/pilots were made aware of local MTR’s, which are usually active, and “See and avoid”. The pilot felt the aircraft was close enough that he instinctively turned his aircraft away from the military aircraft. The incident caused no damage to the helicopter or helibase equipment/facilities. People are reminded of military flight activity {high and low level} at each briefing. Helibase receives a morning report on “active MTR’s” each morning at approximately 0700. This information is passed on to helibase personnel/pilots. **RASM Comment:** I received a call from the National Airspace Coordinator regarding this SAFECOM. Contact had been made with the military who said they would brief their pilots. “See and Avoid” is our only defense because the military is not going to stop flying.

**SAFECOM 09-0527** - At approximately 1745 while flying a bucket mission on the fire, a sudden gust of wind spun the Type I helicopter around. The pilot applied power in order to regain control which caused the rotor blades to strike the hubs: causing damage to the blades. The pilot returned to the helibase and safely landed with no further incident. **CORRECTIVE ACTION:** New blades were ordered to replace the damaged blades. The R-6 Maintenance Inspector was notified. **RASM Comment:** This incident will be investigated as an Incident With Potential. A Regional Team will be on site August 2nd. **RASM Update:** On this day the helicopter was ask to work in a narrow canyon where the smoke was making down-hill drops difficult: resulting in up-hill or side-hill drops. The helicopter was completing the 12th drop in its assigned area. Once the water was released, thus unloading the helicopter rotor system, the helicopter spun around into the wind. The pilot reacted to the helicopter spin. Helicopter control movements along with the sudden increase in engine power resulted in 2 rotor blades contacting the rotor hub. The helicopter blades were replaced. The Regional Maintenance Inspector was on the Incident Investigation Team and recommended to the helicopter manager that the helicopter be returned to contract availability on August 2nd.

**SAFECOM 09-498** - After takeoff from the Airbase the pilots realized one small cargo door was not latched. **CORRECTIVE ACTION:** The aircraft landed at the dipsite so the 2nd pilot could get out and latch the door. The mission continued with no additional problems. The HMGB discussed this event with the pilots and spoke with the vendor lead A&P mechanic.
SAFECOM’s continued......

**SAFECOM 09-0522** - Roughly 45 minutes into the flight, the Directional Gyro Compass Card Locked into position. It would not unslave manually. The mission continued utilizing the Compass and the panel-mounted GPS. **CORRECTIVE ACTION:** Pilot had the Directional Gyro replaced the next morning. Notified Regional Maintenance Inspectors who returned to Contract Availability, after faxing Logbook entry. **RASM Comment:** There is no MEL for this aircraft so the flight should NOT have continued as stated above. I contacted the R6 Light Fixed Wing Manager who discussed this event with the pilot.

**SAFECOM 09-0508** - A Cessna entered the Fire TFR and passed directly over the primary fires within the complex. A helicopter sighted the Cessna and made initial contact with the pilot of Cessna who responded on the active victor frequency. The Cessna was at approximately 7,100 MSL which was within 200 feet vertically of the Air Attack platform. The ATGS made contact with the Cessna, informed him he was in a TFR, on an active fire operation, and directed the aircraft to climb above 8,500 MSL. Other fire traffic had been, and continued to be, working at that altitude: including media aircraft. The Cessna was on a potential collision course with the ATGS platform yet the pilot of the Cessna did not initiate the climb as directed by the ATGS. The Cessna pilot stated his destination was Spokane and continued on his initial course, which traversed the majority of the active fire traffic area. The ATGS platform positioned behind the Cessna and followed it out of the TFR to insure visual contact and maintain separation with other aircraft operating in the TFR. **CORRECTIVE ACTION:** The TFR intrusion was reported to the dispatch center immediately and to the UAO upon landing. The National Airspace Coordinator was notified by the UAO. The FAA was informed and is making inquires into this event however the pilot is not cooperating. The National Airspace Coordinator will update this SafeCom at a later date. **UAO Comments:** Process and procedures were followed. Good job Air Attack!

**SAFECOM 09-0506** - Upon finishing the days missions, the aircraft departed for base after checking the weather in multiple areas. The reports indicated that the passes were open and flyable. After attempting to cross the island at mid point, a decision was made to try to cross at a lower elevation on the South end of the island. The weather still indicated flyable conditions and the flight progressed. After reaching the lower pass, a rapidly moving coastal front moved in to the area making a return to starting point too dangerous. The aircraft rounded the island and progressed up the eastern coastline and the weather made crossing the straight unsafe, so the pilot and manager made a go/no go decision to spend the night at Port Alexander. **CORRECTIVE ACTION:** RAMI COMMENTS: Good decision. RASM Comments: Agree, crossing open water with limited visibility is not wise. Excellent decision.

**SAFECOM 09-0487** - Prior to detection flight I was notified by the FBO that the left wing was ‘‘leaking’’ fuel. I did a walk around prior to the pilot arriving to airport and saw the fuel dripping from the overflow valve and a 20 ft puddle of fuel on the tarmac. The pilot arrived about 30 minutes later so myself and the pilot did a walk around together and observed that only one tank was fueled {left wing} and was over-fueled and venting fuel as the air temperature increased. I notified the Dispatch Center and the Forest Aviation Officer/Fire Management, and he advised me to call the Regional Aircraft Maintenance Specialist. RAMI talked with the pilot and concluded that the plane was improperly fueled by the FBO. **CORRECTIVE ACTION:** Mitigation measure is for pilot or mechanic to be present while aircraft is being fueled. A local refresher should be implemented by local units on the responsibilities of fixed wing flight manager. Acting RASM - No further action required.
On the return flight back to airport the pilots of the helitanker reported experiencing light turbulence and heard a “thump”. The left seat pilot, looked out the window to see the snorkel of the Isolair fixed tank oscillating outside the wheel at or near the top of the tank. The pilot witnessed the snorkel, while oscillating, catch a wind gust and curled towards the fuselage and then lose air causing it to fall below the helicopter. This action repeated four times, and it would be worth noting that the helicopter was in trim at this point. Both pilots estimated their indicated airspeed to be about 80 knots in straight and level flight. Upon witnessing the snorkel oscillating they immediately slowed to 40 knots and the snorkel then returned to the natural position under the tank. During the return flight they were flying north into the prevailing wind. The wind on the helibase was at 5mph with gusts to 10mph and it was partly cloudy with building cumulus. They continued on to the helibase at 40 knots. After shutting down the helicopter was inspected and it was discovered that the snorkel end had made contact with the fuselage above and behind the tank. The damage consisted of one to three dents and a crack. The crack was approximately 4.5 inches long at fuselage station 340 and at water line 94.0. The largest of the dents, approximately 4.5 inches, was at fuselage station 340 and at water line 116.0. There were two small dents with associated cracks in the side keel at fuselage station 352 and 356. The Maintenance Inspector was contacted and was able to be on site shortly after the helicopter landed. The Isolair flight manual supplement listed the Vne of the tank with attached snorkel at 110 knots, but there was a note of caution beneath it stating that oscillation could occur and periodic monitoring was suggested. CORRECTIVE ACTION: The corrective action is to pay particular attention to the note in the flight manual supplement, and periodically monitor the snorkel. It would also be worth considering that the snorkel after repeated landings, and the associated flexing that occurs, could have softened the hose resulting in a higher probability of the flexing.

At 2017 helicopter left the airbase on a reconnaissance mission for the fire. Local fire management was on board to assess the new fire in the wilderness. At 2037 a medivac was requested by firefighters on the ground and the helicopter deviated from its mission to respond to the incident. The helicopter made an onsite landing. The patient was already being packaged and was loaded in the helicopter shortly afterwards. The helicopter left the scene with patient and EMT on board and landed at the airbase at 2102, four minutes after official shut-down time for the day {2058}. The landing was performed on the SEAT ramp so the ambulance could drive close to aircraft. To assist with the low light conditions glow sticks were used. The aircraft was left on the SEAT ramp and repositioned to its helipad the next morning. CORRECTIVE ACTION: UAO Comments: Corrective actions were taken related to mitigating the low light hazard with the use of Glow Sticks. Obviously, risk management was being conducted by the personnel involved. We train and plan for Medivac and S&R mission to be requested at any time, but it’s my experience they most commonly occur late in an operational period where we bump up against civil twilight risks. Kudo’s to the personnel and their decision making. Additional Note: Occupants on board helicopter, beside the pilot, during return flight to the included Manager, EMT, patient, two persons from the original recon flight, and one smokejumper for a total of 6 passengers.

During the return flight from a retardant drop on the fire, The AKI called the base to inform us they were returning with an engine that had been shut down due to a problem. They requested the base to notify the airport crash rescue and have them on standby when they landed. The land was completed without incident and the aircraft mechanics met the crew and began trouble shooting. They were removed from service due to a mechanical failure for the remainder of the day. CORRECTIVE ACTION: Mechanics found a faulty distributor to be the cause. Tanker base personnel notify the RAMI and faxed the required signoffs with AMP numbers. The aircraft was returned to contract availability 7/22/09 at 0900. No further action required.
SAFECOM 09-0476 - While performing a longline mission to spike camp on the fire with water and MRE’s daisy chained. I watched the ship pick up the load and depart and then the pilot called helibase with the actual weight of the load vs. what was given, then the pilot stated that he was switching frequencies and about that time I noticed the top load start to drop items out of the net, then the whole load dropped and the pilot came back over the radio and stated he just felt the load drop. I instructed the pilot to see where the load dropped and proceeded out to the place where I saw it drop. I instructed the pilot to return to helibase and instructed my crew to inspect the cargo hook once on the ground. Upon finding the site of the dropped load we took numerous pictures and noticed the rigging didn’t look correct {could have been from the sudden stop} but on one swivel there was only one pear ring attached to the swivel and the other pear ring and lead line was outside the locking ring of the swivel and then on further inspection found the swivel would not lock and appeared broken. CORRECTIVE ACTION: After further inspection with the forest aviation officer we were able to side load the remote hook with the swivel in question and saw a possible way for the load to release. We went back over proper rigging of loads and how to avoid future incidents.

SAFECOM 09-0470 - Pilot states while doing bucket operations on the fire, the pilot was asked to evaluate spot fires adjacent to an isolated outbuilding for possible bucket drops. While flying with a full bucket to said evaluation, the helicopter was enveloped in a heavy cloud of smoke. At that time the pilot released the water to lessen the load on the helicopter and maneuvered out of the smoke for clearer visibility. While maneuvering out of the smoke the empty bucket struck a tree. The bucket was the only equipment damaged and the pilot was able to fly back to helibase with the long line and bucket attached. The bucket sustained an eight to ten inch tear just above the chain at the bottom of the orange exterior as well as snapping one of the exterior support cables. CORRECTIVE ACTION: Upon return to helibase a review of the incident was discussed by the manager and pilot. When the pilot was again asked to fly into the same part of the fire for a very similar mission, the pilot declined the mission. Great decision by the pilot.

SAFECOM 09-0453 - While enroute to the Airport for fuel, a County Sheriff’s Department helicopter involved in a search and rescue operation, flew through the TFR for the Fire. Contact with personnel on board was made at the airport and they stated they were unaware of the TFR. No fire related aircraft were flying on the Fire at the time on the TFR intrusion. CORRECTIVE ACTION: Submitters Comments: Pilot and observer were briefed on the status of the TFR, given radio frequencies for the Fire and advised to make contact prior to transitioning through the TFR. RASM Comments: Good follow-up with the flight crew, however this is technically not a TFR intrusion, Law Enforcement aircraft are exempt from TFR restrictions for wildland fires. It certainly would be prudent for them to be aware of them and try to coordinate their activities, but they are under no legal obligation to do so. Just another good reason for us to keep our eyes outside the cockpit looking for other aircraft. TFR’s certainly help reduce non-participating aircraft, but are not a guarantee.

SAFECOM 09-0375 - We had just had an IA response to a fire south of Morgan. The helicopter had been dispatched but was cancelled by the IC before it got off of the ground. The repeater, Mount Ogden, was working fine all morning and for the dispatch but almost immediately at the cancellation of the helicopter we lost the Mount Ogden repeater. Had this turned into a more serious fire situation we may have had aircraft in the air with no communication and ground resources with no contact to dispatch. This instance is not the only time this has occurred. It has been ongoing for at least the past month and is to the point that the repeater is down every one to two days. CORRECTIVE ACTION: FAO Notes: Radio problem was fixed on July 7, 2009. A contingency plan for dispatch is being developed to deal with radio problems. NASS - Sent to CIO
SAFECOM 09-441 - The I.C. directed the helitanker to make water drops on the upper end of the fire, where the majority of the heat was. Due to the size of the fire {50’ x 50’} the drops were made in two split loads. Before each drop was made the ground personnel {6 helitack crew members} escaped to the same safety spot 100 feet contoured away from the fire and upslope 30 feet. On the 3rd load of drops the A/C made an approach 180 degrees opposite of the previous drops. No positive contact was made with ground personnel of A/C’s new intentions to drop opposite of previous. The drop was made too far upslope, late, and was carried with the wind directly at the ground personnel who were located in their safety spot. All personnel were tossed to the ground resulting in 2 moderate injuries and 4 minor injuries. I.C. made contact with the A/C to return to Base and Air Attack was notified of the injuries and the need for a medivac. The fire was located in very steep {100 percent slope} and rocky terrain. Other new fires were being reported in the same general area causing extensive use of the pre-assigned initial attack air to ground frequency. The decision to request the type 1 helitanker was made due to the commitment of other aircraft to new starts, amount of heat in the fire and the desire to control the fire before dark to reduce the amount of exposure to the ground crew at night in the difficult terrain. CORRECTIVE ACTION: FAO comments: This has resulted in considerable discussion, investigation and assistance by many folks. The AAR and recommendations by the RAO seem adequate with future prevention of a reoccurrence. RASM Comments: A through AAR was conducted by the Forest Safety Officer, helitack crew and helicopter flight crew. A number of Lessons Learned were produced from this AAR and all involved felt it was very productive. Lessons Learned: 1) Always maintain positive contact with ground forces. If unable to make contact, wait until contact is re-established before continuing mission. 2) Air and ground resources need to constantly evaluate the need and the capabilities of aircraft in use. Are we using the right tool for the job? Risk Management! 3) Constantly evaluate the distance of safety zones, in relation to size of aircraft and volume of water being dropped. Slope & topography were big contributing factors. 4) Firefighters went from suppression mode to rescue mode in seconds. All incident personnel were current as medical first responders and used their training in first aid and specialized training in medivac procedures. The two patients were treated and packaged on scene, then moved to the local airport for medivac to a hospital within 30 minutes. All appropriate protocols and procedures were followed by firefighters, dispatch, and air operations.

SAFECOM 09-0438 - I noticed an unidentified aircraft approaching the incident on AFF. The unidentified aircraft was in direct line with the flight path of incident helicopter resources. Our helibase communications unit attempted to make contact with the Air Attack to advise him of the aircraft location. The Air Attack was at the north end of the fire and unable to see or contact the unidentified aircraft. The aircraft continued into the airstrip and landed. The aircraft departed the airstrip and proceeded to fly directly over our helibase and continued SE. Once again no effort was made to contact either our helibase or check in on the assigned frequency for the TFR. This action is of great concern because the aircraft flight altitude during both his landing approach and departure was the same as our helicopters flight altitude when traveling to and from helibase. To our knowledge no flight plan had been filed or forwarded to any of the affected National Forest dispatch offices. We were barely able to make notifications to the helibase before the aircraft was in the immediate area. We are very thankful that no mishaps occurred from this action. CORRECTIVE ACTION: Submitters Comments: Our hope is that this safecom will increase the awareness of those using a airspace near an incident to check for TFR’s and file a flight plan and have it forwarded to the affected agencies along their route of travel. This incident did not result in any injuries or damage, and we hope someone was flight following the aircraft home. RASM Comments: This aircraft was being used to shuttle a relief crew into the fire and did stay clear of the TFR, however it was crossing through the flight path of the helicopters for the incident on its descent and climb to the airport. The sending agency failed to coordinate the flight with the receiving unit so it was unexpected to them.
SAFECOM 09-0430 – Wingtip sapling/brush strike on takeoff from backcountry airstrip. Mission was to de-mob smokejumpers and conduct backcountry pilot upgrade training was at three other locations before the de-mob. Prior coordination with dispatch was accomplished. The last of the three locations landing was uneventful; winds light & variable 3-5kts, sky clear, approx 80 deg f. after landing rollout, the instructor pilot (IP) highlighted to the upgrading pilot (UP) a known sapling-tree encroaching hazard at midfield on the runway. Engines were left running and a pre-takeoff briefing was conducted prior to brake release. The briefing included short field considerations, emergencies on takeoff, and a up query about the encroaching tree hazard. While in ground effect {1-2 feet in the air} during takeoff the left wingtip made contact with a small sapling tree midfield. The physical bump was felt by both pilots. Climb out was normal. The IP took the flight controls, continued down canyon, and directed the UP to inspect the left wing for visible damage. From the cockpit, damage appeared minimal with scratches to the wing de-ice boot and an approximate 1-2' inch shallow divot in the leading edge of the wingtip. The IP then had the UP climb to 9,500 feet' and perform a controllability check. The check was performed with full flaps, airspeed at VMC, and 30 degree check turns. It was decided that no flight control anomalies were present and to continue to airstrip for landing. Following shutdown a visual inspection was performed and the only additional damage noted was to the plexiglas reflector assembly for the wingtip position light. CORRECTIVE ACTION: The Smokejumper Supervisor Pilot was immediately notified of the incident and the decision was made to restrict dispatching the DHC-6 into this airstrip until such time as the tree encroachment hazards are corrected. Acting RASM: Regional maintenance was notified and cleared the aircraft for flight following the sappling strike. Minimal damage to wing tip. The pilots took appropriate actions prior to and after the sappling strike. This airstrip has been an issue for many years with trees encroaching the runway. The Regional Office and the forest have had recent discussions about the condition of this airstrip prior to this incident. Standardized inspections and maintenance standards have been developed for implementation.

SAFECOM 09-0421 - After the aircraft shut down after the days operations, the evening post flight inspection and a phase three inspection was being performed. It was during that time that the crew chief noticed a crack in one of the tail rotor blades. After this was realized, the helicopter manager, the helibase manager and the regional aircraft maintenance inspector were notified. CORRECTIVE ACTION: Submitters Comments: After the crack was identified the crew chief and mechanic began work to replace the cracked blade. By the next morning the tail rotor blade was replaced and the pilots performed a run up on the aircraft to ensure everything was ok. After the run up was completed the pilot in charge notified the manager that the aircraft was good and ready for missions. The manager then contacted the regional aircraft maintenance inspector to notify them that the work was completed, a message was left, by the manger and crew chief, stating what work was done, soon after the maintenance inspector contacted the crew chief and gave the ok for the aircraft to be placed back into service. There was no loss of availability. R5 RASM Comments: I will follow-up with RAMI, but have to assume that there was no indication of this damage being a result of a rotor strike or anything of that nature. Good pickup on the post flight to detect this.

SAFECOM 09-0365 - Started machine on I.A. to Fire. NG gauge on dash not working but NG gauge in door was working. Manager terminated flight due to no M.E.L. {both gauges need to be in working order). CORRECTIVE ACTION: Submitters Comments: Mechanic notified, maintenance director of company authorized removal of dual gauges, ship running on original set of gauges. Maintenance inspector returned helicopter to contract availability. RASM Comments: Very good call by the Manager. Don't be tempted to proceed with the mission if you have malfunctioning gauges or equipment.
SAFECOM’s continued......

**SAFECOM 09-0412** - While delivering a load of water to the incident after dropping the load, pilot felt a YAW in the helicopter. Pilot confirmed with co-pilot that the number 2 engine was no longer working. While clearing the incident the crew secured the number 2 engine. They notified air attack immediately of the situation and that they were returning to Airport. Additional notifications went out to Dispatch and the helibase. While en route to airport they contacted the crew chief and notified him of the situation. Once at airport they circled airport in order to burn off more fuel and lighten load then proceeded to do an in ground landing. They landed at airport with no incidents. Crew Chief confirmed that the number 2 engine was no longer operable. Company was notified and a replacement engine was shipped. Manager notified COR, Air Operations on Incident, and dispatch that helicopter was unavailable, then contacted Regional Maintenance of situation. CORRECTIVE ACTION: Regional maintenance, COR, Helicopter Coordinator were notified. Regional maintenance inspector enroute to inspect engine change.

**SAFECOM 09-0406** - Four large pieces of angle iron, 200 pounds each, were rigged using a nylon rigging strap {rated at 3000 pounds}. All four pieces were identical, about 16 feet long with a mounting plate at one end. The iron was stacked with the mounting plates together and the rigging strap was attached below the brackets. The other ends of the iron were secured with glass tape. The load was attached to a 100 foot longline and flew away from the lookout very smoothly. About half way through the 5 mile flight, the pilot felt the load release. He then watched as the iron fell 1000+ feet to the ground where it struck a tree and came to rest at the base of it. The pilot recorded the Lat/Long and personnel were later sent to retrieve the lost items. Upon returning to the lookout, the swivel and the majority of the cargo strap was still attached to the remote hook. The square edge of the iron appeared to have cut through the nylon strap. CORRECTIVE ACTION: The cargo strap was inspected prior to use and showed no signs of wear or deterioration. The straps along with several like it are typically stored out of sunlight. The straps are not used often but they are several years old. A metal lead line was utilized as a choker to retrieve the lost iron. All remaining straps of this type at the base have been removed from service. New straps will be purchased for future projects. When flying metal objects, we will continue to use metal lead lines to ensure that they cannot be severed. FAO comments, 7/16/09. Debriefed HMGB, concur with his assessment. Straps may have become brittle over time, and/or deteriorated from UV exposure. In future, will confine use of nylon straps for rigging of non-metal loads.

**SAFECOM 09-0397** - On July 4th the helicopter was on final approach to airport when the pilot encountered skydivers descending to the airport field. The pilot in command aborted the landing. Once the skydivers were not compromising the landing, the helicopter landed at the airport. CORRECTIVE ACTION: A district representative was in place for the arrival of the aircraft and in communication with the Beaver Oaks Airport owners. The airport owners advised the representative of the requirements and directions on use and operation of the aircraft at the airport. The breakdown was found in that the information was not given to the aircraft upon arrival or after arrival. A face to face with the HMGB, HMGB {T} and landowners occurred before leaving the airport. The landowners were advised of the pilots concerns and their corrective actions, as well as an explanation on what they observed. All parties involved were contacted and were advised where the breakdown of communication occurred to avoid similar situations in the future. UAO Comment: The local Hazard map has been updated, informed Columbia Dispatch of the skydiving operation located at Beaver Oaks Airport. In addition, Columbia Dispatch will document in ROSS and will advise approaching aircraft to use local airport frequency of 118.25 if airstrip is used in the future. Also, contract individuals advised that local land agreement needs to be updated for 2009.
SAFECOM 09-0392 - Helicopter returned to the Helibase after completing one full cycle of bucket work on the Fire. The pilot picked a full bucket just off the helibase so the mechanic could look at the bottom of bladder. I noticed that the bucket was bigger than normal. Pilot released load, landed and shut down. Mechanic was checking purse strings and he asked me what our allowable was and I told him. He then informed me that the bucket was set at 90 percent which would put the aircraft outside of the allowable payload on the load calc. I questioned the pilot and he informed me that he had to have his bucket opened up so he would be able to pick more water than if he was at 80 percent. Pilot was using a shallow creek. Previous dip sites were a lake and a river. Before being dispatched to this Incident, the bucket was set at 80 percent which allows helicopter to operate within the allowable weight on load calc. Corrective Action: Submitters Comments: Notified helicopters homebase, FAO, National Helicopter Program Manager and the companies Chief Pilot. At this time I am awaiting further action from the company & National Helicopter Program Manager for advice. RASM Comments: Pilot has been replaced by the company and his status will be monitored by National Helicopter Program Manager. Good job of paying attention to what is going on with this helicopter by the manager.

SAFECOM 09-0388 – On 7/7/09 we had our helicopter at an off base site for training. We were dispatched to a fire, along with the local fixed wing and rotor wing aircraft. Once airborne I contacted dispatch to tell them we were responding. While talking with them I confirmed which other aircraft were responding as well as the air frequencies. I was given Air Tactics 1 and FS air to ground and our normal rotor wing victor. As we neared the area of the fire we knew the fixed wing would beat us there. We attempted to reach the ATGS on air tactics and victor several times. When we got closer to the fire area we could see the fixed wings. We continued to call on the radio as we held out of the area to the north. I was about to change frequencies to another we use in the area to see if they were on that when the ATGS contacted us on victor. We asked what frequencies they were dispatched with and told they were on air tactics 22 which they received from the tanker base do to their being dispatched by their agency. We were cancelled at this time and returned to our home base. CORRECTIVE ACTION: Submitters Comments: After all aircraft where back on base, I went next door to talk to the ATGS and the tanker base Mgr. When I got there they were already in discussion about what happened. They called dispatch, which is a joint dispatch office, we were told that the dispatch knew there were problems with the dispatch as both depts. sent full responses on their own frequencies both ground and air. As a group here at the base we are trying to make sure we all are on the same frequencies before dispatch. One suggestion is to go out on the same air tactics no matter who is in charge of the fire. But this needs to be taken care of at a higher level then we seem to be able to do. This was the second time this week we have had issues with air frequencies on fires in the county. FAO Comments: This is the second SAFECOM’s to be filed within 5 days in regards to some dispatching and communications problems on two incidents. I spoke with the Airtanker Base Manager, the Forest Service Dispatch Center Manager and the Helitack Captain in regards to the background leading to the problems. At this time it appears some breakdowns in procedural methods and policies due to multiple fires in multiple jurisdictions, coupled with new personnel have resulted in procedural mistakes in the dispatching. The aviation resources and the airtankers base have been reviewing the incidents with the dispatch center and are working on making the necessary corrections to try and ensure that this does not occur again. Communication between all of the interested parties is taking place with some AAR's being conducted to correct the mistakes. RASM Comments: The work being done to resolve this locally is very good and both agencies and bases are working together to get an acceptable resolution.
SAFECOM 09-0387 – Issue occurred on the second rappel of a new rope {manufacture date 06/09} completed at 250 feet in flat/open. During inspection one of the crewmembers asked the spotter to look at ‘possible sap’ on the rope. There was no tackiness around the slight discoloration that would indicate sap or any other sticky substance and both rappels had been into an open meadow. The rappeller thought it could possibly be a splice/knot in the rope. CORRECTIVE ACTION: Submitters Comments: It appeared something was wrong with that particular bundle, however it was not readily obvious what the problem might be. Spotter pulled the bundle out a little bit to look further at the area. Spotters best guess was that some dirty ‘fuzz’ was woven into the rope, but it would take pulling the area out completely to see if it was indeed a separate piece of fuzz or a defect actually in the bundle. Spotter decided to take pictures and await further direction, but recommended pulling the area out completely. Emailed pictures and described the problem to MTDC, R-2 HOS and Rappel Working Group Chair. Direction was received to attempt to remove the ‘fuzz’ without damaging the fibers beneath it. Spotter was able to remove the fuzz and there was no visible damage to the bundle. It did indeed seem to be a piece of dirty fuzz, possibly from the braiding machine, that was picked up and woven into the rope when it was being braided. Per direction from MTDC, another detailed inspection of the rope was completed. No additional defects or areas of concern were noted, and the rope was placed back into service. HOS: Correct Action taken, good job on inspections. Keep up the good work. RAO: This rappel group has found a couple issues with their equipment. Good thorough inspections and timely reporting from the crew. No further action required. FAO - Inspected, Reported. No further action required.

SAFECOM 09-382 - Helicopter was participating in a long line mission on the Fire. On initial approach from the south, a HECM {T} was calling in the aircraft when suddenly the net hit a tree with what was described as a substantial impact. The pilot was immediately notified after the load was placed and replied that the sun had glared off of the lake adjacent to the fire, and he had lost visual momentarily. Upon his second approach from the north, the load again grazed the top of a tree before being set down on the sling site. The pilot was notified about the second incident, replied that the wind had got him, and returned to the helibase after placing the sling load. At the time of incident, the winds on the ground were noted at 2-4 mph out of the west, and the pilot reported squirrelly winds at his altitude. After landing at the helibase, the pilot immediately notified the manager of the incident and stated he had lost visual of the loads because of the reflection of the sun off of the lake. No air operations were conducted after the incident. Appropriate contacts were made to the Forest FAO, IC, and personnel on the ground for clarification, notification, and confirmation after the incident. CORRECTIVE ACTION: Discussed possible mission complications such as low visibility, poor communications, sling spot size, wind, long line length, etc., and how to mitigate those complications using various pathways including denying a mission. RASM Note: Follow-up with the Helicopter Manager revealed that this was the pilot’s first Forest Service Contract. The Helicopter Manager flew to the fire with the pilot to evaluate the helispots. After verifying the helispots were adequate, the pilot did some sling load work with noted improvement and no further incidents. The manager encouraged the pilot to voice any concerns with loads, spots, etc over the radio, take his time, be comfortable with the mission. The pilot indicated he felt a little rusty with the longline at the beginning of the season and that the bubble window was exacerbating the sun’s glare off the lake.

SAFECOM 09-0368 - While in transit to an off-Forest assignment a fuel stop was made. After getting fuel the mechanic began his inspection and noticed a tip cap slipping off one of the tail rotors. There was approximately a half inch gap on one side of the tip cap. CORRECTIVE ACTION: Submitters Comments: New tail rotor was flown in by the company and replaced. RASM: It's easy on a normal fuel stop such as this one to be complacent about the pre-flight when jumping right back in the aircraft you just landed in and continuing on. This shows that it's always a good idea not to do this and take the time to do a through walk around and pre-flight to make sure things are still in good order. Excellent job by the mechanic. Thanks
SAFECOM 09-0372 - While working as the Communication Duty Officer (CDO) at NIFC, in the National Interagency Incident Communications Division (NIICD) at approximately 1100 MDT. I was on the phone with a GACC and was given the information that the XXXXX Fire, was using a frequency of 136.075 Mhz for Take Off and Landing Communications. This frequency had never been ordered and the GACC was sending a request to have it filled. The incident had been using this frequency for about three days. I told the GACC that I would have to request a frequency from the FAA and that this was an unauthorized frequency and the incident must stop using it immediately. The FAA no longer uses frequencies above 136.000 Mhz. I was told that this frequency was just pulled out of the air by someone and they decided to use it. The fire was given to a new incident organization and was now called the YYYY Fire, and they were trying to clean things up. The Aviation user community needs to understand that frequencies are a National Resource and MUST be coordinated. The policy and direction of the FAA requires that every incident Air to Air AM frequency request must be placed through the FAA on a per incident basis with a Lat/Long as a center point. The National Interagency Fire Center in coordination with the FAA have pre-assigned IA VHF AM frequencies in all initial attack zones. These are FAA resources and we must comply with the directions given for the protection of not only firefighting aircraft, but to also provide protection to commercial and general aviation. I placed a request to the FAA contact for the Region, and was told it would be two to four hours before a frequency would be available. I called NICC and told them that it would take the FAA two to four hours to engineer a frequency for us and they said they would pass the information on to the GACC. At 1340 I called the GACC again to reconfirm that the fire had been told not to use that frequency and to see if I could get a name of someone that may have authorized the use of 136.075. I was told that no one was taking ownership of making the decision. This seems to be an inherent problem during fires. Someone has used a frequency before and it worked so they think that they are OK to use it again. When the fact is all frequencies must be coordinated. This is a major issue when someone uses a frequency that is not cleared for a specific area, they could be jeopardizing not only the agency resources, but all aviation resources. The NIICD CDO has given information to all GACC’s that all A/A AM frequency requests must go through the FAA and all requests should be sent in early. This is not a new policy this is the third fire season that we have been doing this. CORRECTIVE ACTION: Submitters Comments: This problem was mitigated by telling the incident to stop using frequency 136.075 and the GACC sending a ROSS request for a new frequency. I contacted the FAA at 11:15 MDT to request a new frequency. The FAA filled the frequency request at 15:00 Due to the length of time it can take to fill a frequency through the FAA, we advise GACC’s to request frequencies early. A resource order is not required to begin the ordering process through the FAA. RASM Comments: This is a serious issue in that if you are using an unauthorized frequency you really have no idea of the potential consequences to someone else that is an authorized user. Having clear discreet frequencies for our operations is extremely important and in some cases if it cannot be achieved then it becomes a safety issue. The resolution to an unsafe condition such as this IS NOT to arbitrarily pick a different frequency to work off of. We must go through the approved process of obtaining an approved frequency for our use. If the operation cannot be continued safely while waiting for the approved frequency then you need to either scale operations down to where they can be done safely or stop them all together. Independent action of using unauthorized frequencies will not be tolerated.
SAFECOM 09-376 - Helicopter was committed to a fire performing bucket work with a 100 foot long-line. While approaching a target, ground personnel noticed that the bucket was approx 5 to 10 feet below the tree canopy. The pilot maneuvered the bucket past a tree in which it brushed against the upper branches and then completed the water drop. Ground personnel notified the pilot that he had made contact with the tree. Pilot then continued to perform bucket work at a higher elevation without any other issues. Corrective Action: Submitters Comments: It was identified that that the aspect of the fire the helicopter was working at the time was shaded and emitting a fair amount of smoke and was the likely cause of the pilot’s error in height adjustment. Manager was able to speak with ground personnel about the situation and then debriefed with the pilot about maintaining safe and adequate elevation above targets especially when visibility is hampered by smoke and or shaded slopes. The bucket was inspected and no evidence of contact or damage was found. RASM Comments: I met with the pilot in person and counseled him about the concern for both his safety and ground forces working around him and that he needed to maintain an altitude that would keep the aircraft and bucket at a safe altitude that allow for a margin of error in case of downdrafts or misjudgment on approach.

SAFECOM 09-0367 - Pilot Comments: After Coming out of the dip site, I started climbing up the ridgeline towards the fire. I turned left to cross the ridge a little too soon and contacted the top of a snag with the bucket. I felt a slight jerk on the helicopter and initially thought it was turbulence because it had been windy all day. I looked down and the bucket was torn open and all the water had fallen out. I advised the helibase and returned to base. CORRECTIVE ACTION: Submitters Comments: Manager discussed with the pilot that he needs to maintain his Situational Awareness of his surroundings when conducting bucket operations with a longline and to maintain control of a sense of urgency. RASM Comments: We have experienced a number of these incidents where the bucket contacts either the ground or vegetation, when working the bucket on a longline. Pilots need to maintain an altitude and approach that keeps the bucket well clear of obstacles. Having the bucket hanging down 100 or more feet below the helicopter does not mean that it is OK to get the bucket closer to where you are dropping or transitioning. Maintain your situational awareness and an adequate buffer for safe operations.

SAFECOM 09-0362 – The mission was to sling supply materials to a remote fire lookout. After all helitack personnel were clear, the pilot began lifting the first cargo net off the ground, and determined that it was heavier than previously thought. The pilot informed ground personnel that he was going to set the net down, and release the hook. He went to release the remote hook, and accidentally released the line from the aircraft cargo hook. The pilot immediately informed ground personnel that he had pushed the incorrect button and landed. During the AAR the helicopter crewmembers and trainees opened the cargo net to confirm weights. They realized that a propane tank which was labeled 65lbs actually weighed 175 lbs, creating a load that was 110 lbs heavier than initially manifested. {This new weight was still within the allowable payload stated on the load calculation.} CORRECTIVE ACTION: During the AAR the helicopter manager stressed the importance of accurately weighing all items, the importance of maintaining SA during all facets of external operations, and maintaining a safe distance away from external cargo operations. Also, during the AAR the load master presented several points of lessons learned. First, designate only 1 person as a load master. Second, when utilizing trainees to construct cargo nets reduce the numbers of personnel involved by focusing on 1 or 2 nets at a time: and then proceed to the next. UAO Comments: Corrective actions were discussed. No further action required. RASM Comment: Accidental releases are common every year at the beginning of the fire season. Discuss with your pilot what to expect if the load needs to be released and ask the pilot to review switch positions to help avoid this type of event.