

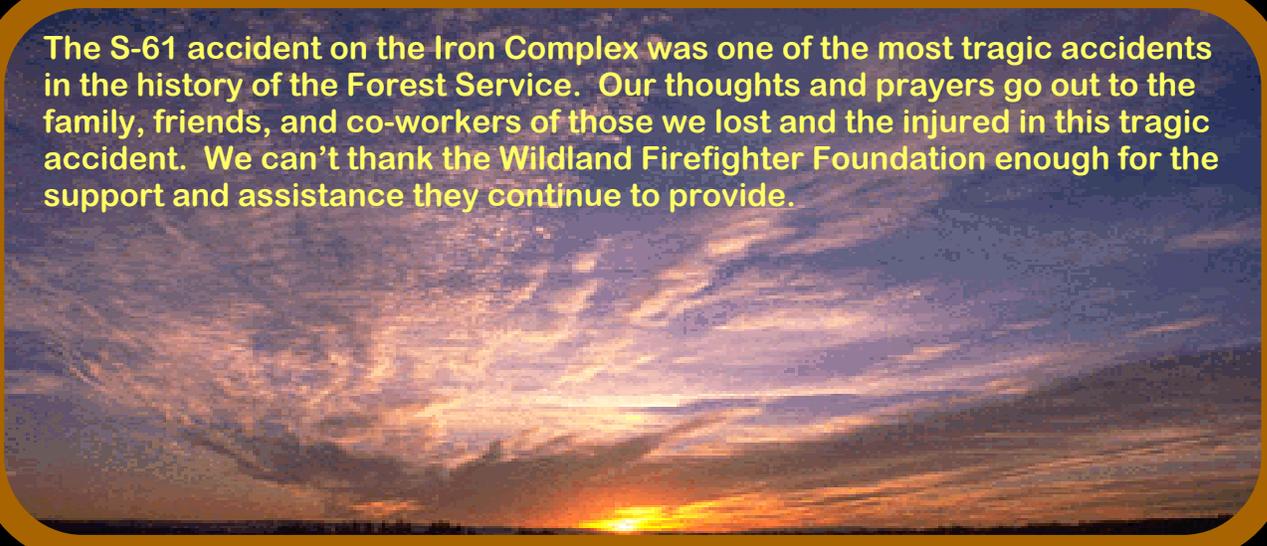


August SAFECOM Summary



FOREST SERVICE AVIATION RISK MANAGEMENT

The S-61 accident on the Iron Complex was one of the most tragic accidents in the history of the Forest Service. Our thoughts and prayers go out to the family, friends, and co-workers of those we lost and the injured in this tragic accident. We can't thank the Wildland Firefighter Foundation enough for the support and assistance they continue to provide.

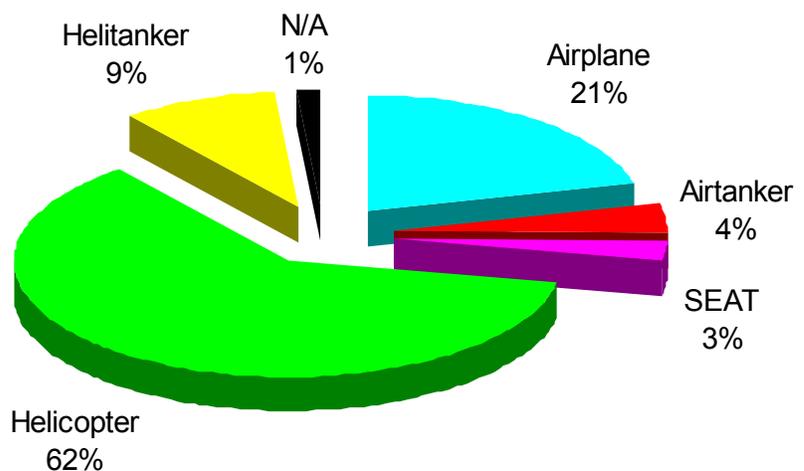


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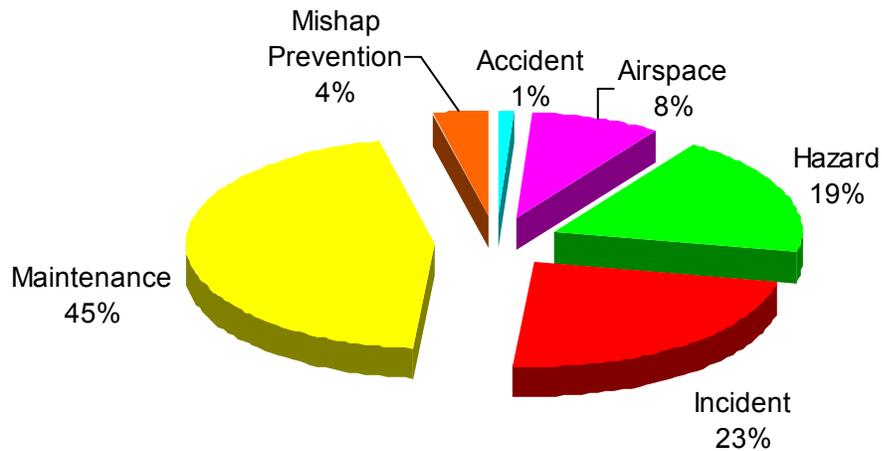
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SAFECOMS by Aircraft Type

For the month of August there were 143 USFS SAFECOMs submitted, well below the 10 year average of 202. Of the 143 SAFECOMs; 30 were for fixed-wing, 6 for airtankers, 4 for SEATS, 88 for helicopters, 13 for helitankers and 2 N/A..



SAFECOMS by Category



ACCIDENT— There were two accidents in August. Both accidents were helicopters performing firefighter transportation. The S-61 accident was one of the most tragic accidents in the history of the Forest Service. The Hughes 369 accident had a much better outcome, with no injuries. The NTSB reports are included.

NTSB Identification: **LAX08PA259** 14 CFR Public Use
 Accident occurred Tuesday, August 05, 2008 in Weaverville, CA
 Aircraft: Sikorsky S-61N, registration: N612AZ
 Injuries: 9 Fatal, 4 Serious.

This is preliminary information, subject to change, and may contain errors. Any errors in this report will be corrected when the final report has been completed.

On August 5, 2008, at 1941 Pacific daylight time, a Sikorsky, S-61N helicopter, N612AZ, experienced a loss of power to the main rotor during takeoff initial climb, and subsequently impacted trees and terrain near Weaverville, California. Post-impact fire destroyed the helicopter. The airline transport pilot and 8 passengers were fatally injured, and the commercial copilot and 3 passengers were seriously injured. The helicopter was being operated under contract to the United States Forest Service by Carson Helicopter Services, Inc., as a public-use flight. Visual meteorological conditions prevailed for the cross-country flight that was originating at the time of the accident. A company visual flight rules (VFR) flight plan had been filed. The helicopter was departing from Helispot 44 (H-44, elevation 5,935 feet) en route to Helispot 36 (H-36, elevation 2,516 feet) when the accident occurred.

The helicopter had been assigned to transport approximately 50 wildland firefighter helitack crewmembers out of the Trinity Alps Wilderness of the Shasta Trinity National Forest due to forecasted worsening weather conditions. The helicopter had completed two trips, and had gone to Trinity Helibase to refuel. After it had refueled, it returned to H-44 for its third load of passengers. During departure, the helicopter impacted trees and subsequently terrain, coming to rest on its left side. A post-crash fire consumed the aircraft.





Aviation in itself is not inherently dangerous. But to an even greater degree than the sea, it is terribly unforgiving of any carelessness, incapacity or neglect.

— Captain A. G. Lamplugh



SAFECOMs by Category continued

NTSB Identification: **SEA08TA188** 14 CFR Public Use
 Accident occurred Monday, August 18, 2008 in Bonners Ferry, ID
 Aircraft: Hughes 369D, registration: N622PB
 Injuries: 4 Uninjured.

This is preliminary information, subject to change, and may contain errors. Any errors in this report will be corrected when the final report has been completed.

On August 18, 2008, at 1640 Pacific daylight time, a Hughes 369D, N622PB, collided with terrain near Bonners Ferry, Idaho. The United States Forest Service (USFS) was operating the helicopter as a public use flight. The helicopter sustained substantial damage; the commercial pilot and three passengers were not injured. Visual meteorological conditions prevailed and a visual flight rules (VFR) company flight plan and flight following were in effect. The pilot departed from Bonners Ferry Ranger Station about 1600.

According to the USFS safety officer, the pilot was picking up firefighters and had landed on a pinnacle. After loading the helicopter, the pilot began to depart and 10 to 15 feet above the horizon and approximately 30 to 40 feet above the trees, the pilot was having difficulty maintaining altitude in the helicopter. He then performed a 180-degree turn back to his departure point and the helicopter landed. During the landing, the tail rotor drive shaft sheared. This accident was upgraded from an incident on August 25, after verification of the helicopter damage.



AIRSPACE — Fourteen Airspace SAFECOMs were reported, which is well below the average of 24. The good news is that there were no near mid-air reports. By sub category there was 1 conflict, 8 congestion, and 5 intrusions. Air-Attacks need to make sure they identify what fire they are on, i.e., Big Bear Air-attack. Aircraft were cleared into FTAs only to find out they were cleared by Air-Attack from another fire. We've had some comments again on websites not showing current TFR data. The web site the USFS recommends, with the most current TFR data available, is the DINS website at: <https://www.notams.faa.gov>. Please advise our pilots, contractors, and cooperators. Thanks.

HAZARD — **Houston we have a problem.** Communications continue to be our most common hazard. Over half of the SAFECOMs in this category (18 out of 31) were communications related. The number of frequency congestion reports however were insignificant compared to the last few months. Once again, poor mission instructions and procedures, wrong frequencies on resource orders, and entering TFR's and FTAs unannounced were the bulk of the issues. There were a few instances of lack of communication, not discussing safety issues on the spot and filing a SAFECOM a week later, and complaining to your home unit or blogging after being demobed. PLEASE communicate and resolve the problem on the spot. The policy deviation reports consisted of continuing with a mission after an incident, transporting passengers in helicopter configured for PSD mission, and being by the aircraft while fueling.

SAFECOMs by Category continued



Don't get
Overloaded!

Flying is so many parts skill, so many parts planning, so many parts maintenance, and so many parts luck. The trick is to reduce the luck by increasing the others.

— David L. Baker



INCIDENT— There were 39 Incident SAFECOMs reported and almost half (19) of them were dragged and dropped loads. The number of dragged loads (5) were slightly down from last month, but the number of dropped loads increased significantly (14). We're just darn lucky we haven't had an injury from all the dropped loads. This is a serious issue; review the risk assessments for dropped loads and discuss in daily briefings before we're out of luck. There were 7 precautionary landings, mostly due to mechanical issues. Good job on making those precautionary landings; much better than a forced landing. There were two Incidents With Potential (IWP), a gear up landing and a ground rotor strike. The IWP SAFECOMs are included in the SAFECOM section.

MAINTENANCE — Seventy-five (45%) of the reports submitted were maintenance related. As usual, the most reported were a wide variety of engine (21) issues. There was one engine failure on a twin engine aircraft. There was a significant decrease in chip lights and electrical problems reported. Problems with landing gear was significantly higher than normal, one was the result of an IWP. There were 6 problems related to the mission equipment and another seatbelt problem identified. [Safety Alert IA 08-09](#) discusses issues with the 4-point harness, but it applies to all types of restraint systems. Any restraint that is broken should be reported immediately and taken out of service.

MISHAP PREVENTION— There were six reports in this category: pilots that turned down missions due to visibility; vendor turning down a flight stating they did not have the right aircraft for the mission; dipsite manager noticing aircraft door open and immediately notifying pilot to land; longline in trees with excellent communication between the pilot and firefighters as well as thorough follow up and discussions; mechanic noticing problem with tail rotor when aircraft was spooling up and immediately notifying the pilot to shut down. Great job and thanks for speaking up, resolving these potential hazards, and then reporting them.

**Great Job
Thanks**

SAFECOMs

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

[SAFECOM 08-0878](#) While flying north-east the bottom of the bucket {w/longline} made contact with the ridge line {runs N to S}. The pilot released the remaining water and returned to the water source. Pilots statement: While transitioning on a ridge line, pilot failed to manage the height of the bucket. Bucket touched the ground, pilot released the water then returned to water source. No damage to bucket, no personnel in the area. Talked to pilot about height of bucket and ground sources to talk to the pilot about the height of the bucket. Talked to pilot about height of bucket and ground sources to talk to the pilot about the height of the bucket. Acting RASM: Regional HIP also discussed issue with the pilot and counseled on good situational awareness.

SAFECOM 08-0881 During the extended attack phase of the fire, 2 incidents occurred involving fixed wing retardant drops on DIV A. Approximately 1500 Air Attack was contacted by DIVS A who asked for a load of retardant to be dropped on the north side of the fire to tie in a piece of fire line out ahead of the ground crews. Air Attack put the request on hold for higher priorities. Two hours later Lead and a SEAT made the live retardant run without contacting any ground resources, 8 ground personnel working in the area narrowly missed being hit by the drop. The 2nd incident occurred at about 1910 hrs. Air Attack had departed the incident for fuel and left Lead to continue to coordinate the aerial resources. Several retardant drops had been made previously on the south flank of DIV A with a combination of SEAT"s, P2V"s and P3"s . All crews had been pulled back to the SW corner of the line until the retardant line was complete. Lead contacted DIV A to let me know there was one more drop available. DIV A stated that it wasn't a critical need on that flank. Lead stated that there were no other current needs for the load on the incident so DIV A advised to tie into the last drop. After the dry run, Lead and Tanker made the live run. The drop tied in and ran long hitting 2 engines and approximately 10 crew members, which were working 200 yards down from the start point. Both engines were heavily painted as were 3 crew members. DIV A immediately checked on the engine crews for damage and injuries. There were none. Lead made contact with DIV A shortly there after to check on the crews and apologize. Lead stated the tanker had built up too much speed on the run causing the drop to go long. Both incidents were debriefed at the end of shift with all resources working on DIV A. It was stressed that all ground resources need to have increased situational awareness during high tempo aerial/fire fighting operations. It was also stressed that ground crews should not only pull back from the area of retardant drops but move to the side, out of the flight path of the retardant aircraft. It was also noted that one point of contact on the ground should coordinate aerial suppression efforts with Air Attack to alleviate confusion. Acting RASM: Lead was contacted and terrain/airspeed factors lead to the misjudgment of how far the drop would carry. The Division Group Supervisor did an excellent job of follow up with ground troops.

SAFECOM 08-0864 On the initial request for the helicopter information was sketchy. Both the helicopter & ambulance were told to respond. After starting the helicopter a lat & long was received for Hospital and a frequency from the local unit medical plan. Upon arrival medic was on scene and the patient was loaded. Multiple EMTs/personnel wanted to go to the hospital. Personnel on load to hospital: Manager, Helitack EMT, Paramedic, Fire EMT, Crew Boss, and Patient. Upon return trip dropped off Paramedic & Fire EMT at helispot. Discovered that the Lat & long for hospital was incorrect and asked for clarification from Helibase but was read same lat & long. Pilot had local knowledge & knew where to go. Contacted Dispatch & had them call hospital. Said Hospital could not accept Medium ship. Ambulance was at airport waiting for them when they arrived. Ambulance took patient to hospital. The HEB1 {t} on phone with RVMC & said they would make LZ available for helicopter. Security in process of doing so. Do betters: Preload correct lat & long for hospital. Verify size of ship that can use hospital LZs. Call Local Unit Aviation Officer & update them on correct lat & long. Contact Helibase & update them on correct lat & long. UAO comments; Aviation Mishap Response plan has been corrected and forwarded to the field. The Longitude was accidentally inverted when put into the spreadsheet thus ended up as 122 14.91 instead of 122 41.91. Good catch and timely information sharing! Highlights the need to practice a separate method of double checking critical information.

SAFECOM 08-0847 Upon departure it was noted that left cargo door was inadvertently left open. Aircraft was landed and shut-down to check for any possible damage. No damage noted. All crewmembers were re-briefed on preflight procedures. **RASM Comments: Take the time to do a complete walk around and make sure things are secured. Even after a complete pre-flight if the aircraft is sitting on standby for awhile, people get into compartments and move things around, take the time to assure that things are right.**



SAFECOM 08-0861 While doing a Law Enforcement Recon with 15 minute check ins with Dispatch, contact was lost with the recon helicopter. Last positive check in was at 1230. At this time they were over Forest Creek. Next 15 minute check in at 1245 resulted in no positive contact. 1300 check in still no positive contact. Forest Aviation Officer was advised. With his direction we notified the Forest Helicopter, and gave them last location of positive contact. The Forest helicopter was preparing for the search of the recon helicopter. Forest Supervisor, and LE Patrol Captain, were notified. At 1316 positive contact with the recon helicopter was made. They were flying low level and could not hear us. Submitters Comments: Advised person in charge of the mission that when they are dropping down to low to communicate with Dispatch they need to advise the Dispatch office first. Then in 15 minutes they need to come back to a higher elevation to make the positive contact with Dispatch. RASM Comments: Procedures were followed well by Dispatch for missing or overdue aircraft and I agree with the corrective actions as submitted.

SAFECOM 08-0855 Aug. 27th the crew of a helicopter was engaged in rappel proficiency training while assigned to an incident. During this training a crew member was taking off his seatbelt, he was positioned to be the first rappel. During the loading process he noticed that the plastic release button on his seatbelt buckle was cracked. The Captain was seated adjacent to him and acknowledged the find. The flight proceeded as normal. At the completion of the training flight the problem was discussed with the Superintendent of the helicopter module. Further investigation took place by the Captain; he found two more seat belts where the plastic release buttons were cracked. Through consultation with the Regional and National Maintenance Inspectors, the following corrective action was taken. The defective seatbelt buckles were immediately removed from the aircraft by the mechanic and new buckles were installed. All of the remaining buckle assemblies were thoroughly checked for cracks and defects on the release buttons, none were found. The buckles were manufactured by DART for the following Bell model helicopters in use, 205/212/214/412.



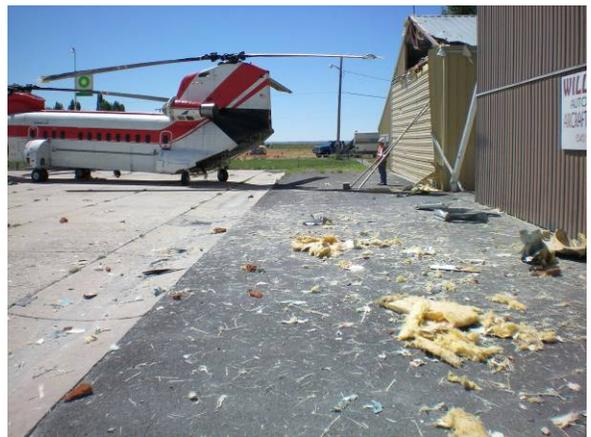
SAFECOM 08-0844 During PSD operations on a prescribed burn, a passenger was transported to an observation point and later picked up with the PSD machine, operator, Ignition Specialist and ancillary equipment {ball bags, operator tether etc} in the aircraft. Interagency Aerial Ignition Guide prohibits transportation of pax while configured for PSD operations. Load on board the aircraft was within limits of the load calculation. FAO counseled operator and Helicopter Manager regarding limiting occupants of the helicopter to pilot, Burn Boss/Ignition Specialist, PLDO and instructor/trainees if essential to the mission. Annual PLDO refresher training will reiterate basic operations and policy. RASM COMMENTS: Good follow up.

SAFECOM 08-0843 ASM module was conducting Airtanker operations on the fire with T-XX. After the drop a helicopter was observed in the exit path. The tanker was notified and both the ASM and tanker extended the exit without any problems. The helicopter was contacted by the ASM and his flight path was altered to facilitate tanker operations. At the time the fire was making major runs in all divisions and the operational tempo was high. With activity on all divisions, lots of smoke and confusing topography aircraft at times were struggling with the layout of the fire. Assure helibase is contacting ATGS when A/C leave the helibase. Consider using A HELCO if/when span of control issues arise. Acting RASM: Good point on the use of a HLCO. The position is not used as often as it should/could be, often due to the perception that there is not a platform available. If the position is needed incidents need to take the appropriate steps to put someone in place.

SAFECOM 08-0842 While stationed at airport it was discovered during pre-flight that the airplane was missing some fuel from its tanks. On further investigation it was discovered that 10 to 15 gallons of fuel were missing. The pilot and recon person started to ask around and see if anyone else was missing fuel, upon checking with a State Air-attack plane stationed at the same airport it was discovered that they were also missing some fuel. Both planes had fueled up the night before at end of shift and topped off the fuel tanks thus knowing that the planes tanks were missing fuel when it was discovered they were no longer full. Corrective action taken was to inform the airport manager where at this time they called the local police department, Aircraft Company, and the Unit Aviation Officer who made contact with the Forest Law enforcement officer. The local police said they would increase patrols at night and keep an eye out for activity around the planes. RASM Comment: With the cost of fuel I'm surprised that this is not more common! Good corrective action. RAMI: To bad we don't require locking gas caps on fixed wing like we do rotor craft....

SAFECOM 08-0836 On final approach back into Helibase from the fire on a cargo mission with a 100" synthetic longline with remote hook, several people including myself noticed the longline whipping violently beneath the helicopter and after a few moments, the longline and hook fell from the aircraft into an alfalfa field adjacent to helibase. The pilot was informed immediately via radio and was unaware that it had fallen off. A ground crew quickly went over to the field and recovered the longline and remote hook shortly after. No damage or injuries occurred. The local winds at the time were approximately 20-25 mph. Airspeed was approximately 40-50 mph. The pilot says he did NOT punch off the line accidentally. We believed that the line worked itself loose from the belly hook somehow. We hypothesized that there was enough "slack" and/or "whip" in the line to make this possible. The only corrective action would be to have a heavier hook or possibly tie the electrical pigtail a little shorter {that is if the electrical cord somehow aided in the longline working itself loose. Acting RASM COMMENTS: Discussed with FAO. Suggested a couple things to check if crew had not already done so. Asked that company mechanic do a thorough inspection of the hook, mechanical, and electrical releases and make appropriate log book entry.

SAFECOM 08-0829 While on ferry flight the aircraft stopped to refuel. The aircraft was taxiing to the fuel site. There was a small plane in the pilot's usual pattern so he attempted to maneuver into the fuel site. He slowly brought the tail of the helicopter around to line up with the fuel site, while doing so his rear rotors caught the airplane hanger adjacent to the fuel site. There were no injuries; however the helicopter and adjacent buildings sustained damage. The metal framed hangar structure heavily damaged the three rear rotor blades resulting in a large debris field stretching out to 100 feet in all directions from the hangar. The hangar, in turn, was heavily damaged by the rotor blades. The aircraft was shut down in place and contacts were made. The FAA was contacted about the incident and a Notam was issued advising aviators that there was no fuel available at airport pending debris cleanup and the removal of the aircraft. Once the FAA had received all their required information they advised the airport management that the aircraft could be moved whenever possible. Pictures were taken by the local sheriff department and the aircraft was moved from the fueling area. Cleanup of the debris was assigned to the vendor. The aircraft will be repaired at the Burns airport. The vendor is planning to change all six rotor blades, the rear rotor head, and the main drive shaft to the rear transmission. During the repair process the aircraft will undergo additional inspections by the vendor to ensure that no other damage is present.



SAFECOM 08-0828 At 1400 a military Chinook entered the TFR of the fire unannounced and proceeded to do a VERY low level recon over the fire area during the middle of the operational period. Fortunately at the time of the intrusion no other aircraft were up over the fire area. The air ops {T} immediately made contact with the FAO and reported the intrusion. The FAO visited the NG unit and reported what had been relayed to him by the air ops. The NG had checked the FAA web site. It was at this point it was discovered that no TFR information for the state of Montana was listed on the FAA NOTAM web site, but the info was on the military site. The FAO forwarded this info to the National airspace coordinator and she contacted the FAA. The problem has been corrected. RASM COMMENTS: The NG unit had done their flight planning, and checked the FAA web site for TFRs (This appears to be a breakdown somewhere on the FAA side of things). The NG had done everything they had been told to do regarding fire TFRs. The good news is that nothing bad happened and that this event may help fix whatever problem there was with getting complete and accurate TFR information on the FAA web site. Good followup by all. NASS: **There have been problems with the FAA and several other web sites, please inform folks to use the DINS website at: <https://www.notams.faa.gov>.**

SAFECOM 08-0825 The air attack aircraft was assigned to a Complex as an ATGS platform. Mission: Afternoon ATGS mission on the Complex Approximately 5 minutes after takeoff from the Airport the pilot reported to the ATGS that the panel light for the left starter/generator had come on {red light}. The pilot informed the ATGS that this condition would not scrub the ATGS mission but that it would necessary to have it checked out upon return to Airport after the mission. The 4 hour mission on the Complex was completed and the aircraft returned to the airport. Upon landing the AOBD for the Complex was notified of the generator indicator light. The following morning the pilot and a mechanic switched the left and right starter/generators and confirmed that the left started/generator needed to be replaced. The aircraft was put out of service until necessary repairs have been made and the aircraft is inspected and returned to service. The replacement starter/generator will be shipped and the aircraft should be able to return to active service by 08/24/08. The replacement part was received and replaced on 8/24/08, the RAMI was notified and the maintenance was approved. However prior to the aircraft being placed back in contract availability the operator was ask to provide the MEL for the aircraft to determine that operations with the starter/generator indicator light illuminated was covered. There was not an MEL for this aircraft, and as such the proper action once the light came on would have been to return to the departure airport. The operator was contacted and informed/reminded of this requirement as was the ATGS. This subject will be added to the Region's ATGS workshop as an agenda item. No further action required at this time and the aircraft was returned to contract availability.

SAFECOM 08-0818 As the COR of an exclusive use contract, I was contacted by a helicopter manager about some operational concerns regarding the helicopter when I came to learn that the manager who called me was acting manager for the aircraft because the exclusive use crew that was attached to the aircraft was demobed by the incoming team - 2 days prior to the end of the contract extension. I thought it odd to demob an exclusive use crew but keep the helicopter so I inquired as to how the helicopter was being staffed. The manager confirmed they were managing the aircraft with one miscellaneous helitack from the helibase. I reminded her that the minimum staffing was manager plus 2 helitack for a type 3 A/C. The manager understood that but didn't perceive that the incident was concerned about the short staffing. The staffing level of one manager and one helicopter crewmember did not meet the required IHOG standards as prescribed in Chapter 2 page 2-4, Item III, for the exclusive use type III aircraft. Nor was any consideration given to "limit" the use of the aircraft to comply with IHOG Chapter 2 page 2-5. This resulted in a violation of the staffing requirements of above IHOG policy. A full briefing as conducted by the Region with the IMT and the Helibase, to address the issues and resolve the situation. No further action is required at this time.



SAFECOM 08-0824 During a passenger briefing for the AOBD he requested an extra helmet to take with him. I inquired as to the necessity, and he stated he was going to land and pick up one person at a helispot (un-staffed) then conduct a recon and drop the other person back off at the helispot. I informed him that unless helitack was on board they couldn't land and load or offload passengers. Air ops informed me he was air ops and was helitack qualified. I explained he hadn't been thoroughly briefed on the ship. The end result of this was that flight did occur but only as a recon with no take-offs or landings other than the Helibase. The events generated by this SAFECOM necessitated a visit to the Helibase by the Region, and discussions were held to address and resolve the potential conflicts and confusions. The following prudent operational and safety items should be completed. 1) AOBD (or other unfamiliar/unassigned resource) should produce a current REDCARD for the HELM to verify qualifications as a HECM/HELM. 2) Helicopter Manager is comfortable allowing the mission as requested by AOBD. 3) Helicopter Manager has had sufficient time to conduct thorough briefing of the aircraft, including any idiosyncrasies that affect use of the aircraft (such as doors/window operation, etc) (this briefing should include the pilot). 4) Helicopter Manager is satisfied with results of the briefing and has no concerns with the AOBD performing HECM duties with this helicopter. 5) AOBD should recognize that while he is performing HECM tasks that he is also under the supervision of the assigned HELM, and because of that, should also comply with the HELM instructions for purposes of completing the mission. 6) AOBD should ensure there is no conflict with duties as AOBD while performing tasks associated with HECM.

SAFECOM 08-0823 During a long line cargo mission to supply a spike camp a 1ft. x 1ft. box weighing less than 1 lb. floated out of a cargo net and landed in brush beside the airport runway. Helitack personnel loaded two cargo nets with food and supplies for a remote spike camp. The nets were daisy chained and connected to the helicopter long line during a hover hook-up. As the pilot departed the loading area and flew the length of the runway, a box floated out of one of the nets. The box had not been secured to other more substantial cargo in the net, nor had the purse strings on the net been collared. The pilot was unaware of the lost cargo. He flew the length of the runway, and continued out of town above undeveloped land before turning towards his destination. Care needs to be taken with lightweight cargo to be sure that is secure inside the net. If the pilot had not avoided developed land during his flight, the incident could have been much more serious. AAR focused on proper loading and securing of cargo. Crew knows better and will use more tape as well as take more time to review the load configuration. RASM Comments: It is certainly appropriate to conduct an AAR to focus on how the event occurred and how to prevent similar instances from happening in the future. The Region has experienced a very long fire season, and it is also worthwhile to mention issues associated with fatigue and burnout. People may be feeling the effects of cumulative fatigue at this point of the season, resulting in reduced ability to recognize details that may become important at a later time. **As stated by the submitter of this SAFECOM, the incident could have been more serious under different circumstances. Remember to monitor crew fatigue and ensure work/rest guidelines are adhered to. Now is a good time to review the SAFETY ALERT of April 21, 2008 regarding fatigue in Aviation Operations. Thanks to the submitter for the report.**

SAFECOM 08-0796 During preflight on 08/13 PIC noticed several strands broken on a tail rotor control cable. This prompted further inspection of all the sections of the tail rotor cable and another damaged section was found. Once removed the second section was found to be damaged further than originally believed. The first section was found and replaced on 8/13 the next section was found and replaced on 8/15. Maintenance flights were flown both times, and the regional maintenance inspector was notified. This was a great catch by the pilots and mechanics. **RASM comments: This demonstrates the importance of the pre-flight action. Proper procedures were followed to return aircraft to contract availability, no further action required.**



SAFECOM 08-0810 After dropping the last load of cargo at the fire, and transitioning up and out of the sling site. The pilot adjusted his hand and inadvertently pressed the electric belly hook release button. The 100 ft longline was released at the sling site. Checked and tested electrical connections and longline. Talked to pilot about situational awareness. On 8/20 pilot flew 1 hr of longline proficiency, with no problems.

SAFECOM 08-0809 While performing gear retrieval off an incident via longline a rappel rope bag opened and the rope deployed from the net. All 250 feet of rope was hanging from the bottom of the net but was still secured to the bottom of the rope bag. Crew at delivery point informed pilot of the situation and pilot laid the rope down in the same manner as he would the longline. Crew secured rope and helicopter landed at helispot. Three sky genie descent devices were lost in route. The entire rope did not deploy until the aircraft was almost at the helispot. There was an AAR with crew on the importance of securing gear that is to be flown out via longline and the potential consequences of unsecured gear.

SAFECOM 08-0803 The Jump aircraft was dispatched to incident 810. After dropping three jumpers on 810, we started cargo ops. On the first cargo drop we had cargo in tow. The spotter quickly cut the fire box free. We did not notice any adverse effect on airplane control. The jumpers are in the process of figuring out what caused the problem and how to correct it. Jump Spotter Comment: Firepacks similar to the "in tow" box were inspected upon return to Redmond. It is believed that modifications to the containers were the cause. Four tabs of webbing stitched with Velcro are used to attach the cargo chute container to the box. We believe that the use of four affixes the chute too strongly to the box and the snatch force is not enough to pull the container and chute away to deploy. We have cut two of the tabs off of the containers and manually pull tested them to assure the container releases from the box with less force.

SAFECOM 08-0812 While in transition from the Airport to the fire the snorkel for the Isolair fixed tank impacted the right underside of the tank. The snorkel appeared to be ""wagging"" much more than witnessed the previous two days flown missions. The crew stated the snorkel had been removed, and the hydraulic lines had been retaped to the hose portion of the snorkel the evening before. The new position the lines occupy caused the snorkel to react aerodynamically differently. The temperature as well was much warmer and they believe the snorkel hose was made much more pliable {less rigid}. Adjustments were made as to where the connections should be positioned. Those positions were marked and as witnessed while the aircraft was in flight, the problem was alleviated. The snorkel now flies in an appropriate manner without a lot of wag. Acting RASM: Even though the impact did not cause any major damage other aircraft using this system should be aware of and look for the same potential problem.

SAFECOM 08-0782 Pilot noticed a TCAS target at 7600 feet approximately 600 feet above the air attack altitude. A turn was made by the reporting pilot to the east in an attempt to identify the target. Subsequent turns to the north and west revealed the target, a fixed wing multiengine aircraft descending approximately 1.5 to 2 miles to the north of the air attack aircraft. The target was on a westerly heading, descending on a course to the airport. The reporting pilot contacted Seattle Center and advised them of the intrusion into the TFR. Helibase was contacted by the ATGS and was also advised of the intrusion. RASM comments: This event is not technically an intrusion by FAA standards. The airport was not closed, and ingress/egress through the TFR is allowed if the aircraft is operating under an air traffic control IFR flight plan, which it was. While this incident does not constitute an "intrusion" it does point out the necessity of communicating intent between agency aircraft on differing assignments. The Leadplane pilot was concerned about adding to the ATGS workload, but a radio call here would have in the end reduced stress and confusion.



SAFECOM 08-0791 A logging helicopter flew thru the TFR set up for the fire. The helicopter was spotted and tracked using aerial flight following. Air Attack from the fire was notified, as was Helibase who was launching a helicopter to do recon work in the area. Aircraft desk was notified and called Company of logging aircraft and discovered that the cited helicopter was doing logging operations south of the TFR. Aircraft Desk requested helicopter company contact AOB and Air Attack for future flight coordination. The Operations Manager for the helicopter Company coordinated with the ASGS on the fire to mitigate this issue. After discussions it was determined that the logging pilot had checked for TFRs prior to his flight, but somehow missed the TFR for the fire. The helicopter Company proposed the following mitigation: 1} Immediate "tail-gate" SAFECOM session with all of their helicopter operations. 2} This occurrence will be included in the company monthly "minutes safety bulletin and will be reviewed by all company employees. 3} The company will provide the pilots with a list of approved web sites to check on TFRs as part of their flight planning. 4} Provide Lat/Long of the logging operations near ongoing fires to enhance the airspace safety in that area. RASM Comments: This is a very proactive approach by the helicopter company, and the resulting mitigation demonstrates their commitment to safe operations for both firefighting and logging aircraft. RASM had follow-up conversation with both the Dispatch Center and the helicopter Company. The helicopter Company did confirm that information relative to TFRs was obtained from the FAA website, and are not exactly sure why the TFR information for the fire was missed. This situation is a good example of people making the honest effort to do everything correctly, and still resulting in an unintentional airspace intrusion. **TFRs are in place to provide a safe flight environment for firefighting aircraft, but they are no guarantee that other traffic will not enter that airspace. It is still essential to practice 'see and avoid'.**

SAFECOM 08-0771 Helicopter informed Air Attack that the late afternoon shadows and the position of the sun made visibility along a portion of the fire line very tenacious. Described as looking into a "black hole". At that time Air Attack had helicopter return to his fuel truck and hold. Approximately 1/2 hour later ground forces arrived in the area and asked if a helicopter was available for bucket work in that area. Another helicopter was doing a line recon. Air Attack asked the helicopter if visibility had improved, the helicopter stated that bucket work could be done by approaching the drop area from a different angle but conditions were not optimal. At that time the decision was made not to support ground units with bucket drops. All parties involved agreed that work on the ground could be safely accomplished without aerial support. Great job by the first helicopter for notifying Air Attack that visibility was degrading and for the second helicopters further analysis of the situation. UAO/SAM: **Excellent job by all parties. Instead of pushing the limits, all agreed that conditions were such that it was time to stop.** This is a good example of identifying a hazard and mitigating. We need to recognize the cooperation from the ground crews as they are in integral part of the operation. If they understand the issues affecting the aviation operation and help with the situation, they deserve recognition for their part in promoting a safe aviation operation.

SAFECOM 08-0769 While picking up a cargo net on takeoff from the helibase the remote hook on the 150ft long line released and dropped the cargo net. The net landed 15ft from the original take off spot of the cargo net. No cargo was damaged. The helicopter landed, the remote hook was tested again {it had been tested before liftoff}. The cargo net was again hooked up and the mission was resumed. Upon returning to the helibase I discussed the incident with the pilot and he admitted to accidentally releasing the load by brushing up against the control switch. RASM comments: Kudos to the pilot for being honest that he made a mistake. Good situational awareness in the cockpit is a must. An AAR occurred with the STAT team on site. Here is also a reminder that folks need to be heads up when working with helicopters above.



SAFECOM 08-0759 Aircraft was ordered to do bucket work on extended attack fire. Manager and crew-members landed in a meadow and deployed bucket. Helicopter flew to dipsite for a load of water & dipsite manager noticed the rear door on the pilot's side was open. He told the pilot to land and he closed the door. There was no damage or any further incident. Pilot continued bucket drops. Pilot informed manager of incident when he went back for fuel. **FAO comments: Kudos to the dipsite manager for paying attention. This is a positive example of the "If you see something, say something" philosophy paying off.** Manager was counseled on the need to do a final walk around on his aircraft prior to missions. RASM comments: Concur with FAO comments, appropriate action taken by dipsite manager, pilot and FAO.

SAFECOM 08-0753 Takeoff from Airport for Air Attack mission, normal taxi, run-up, and takeoff. When the Pilot cycled the landing gear to the up position he noticed a red light near the control indicating a problem with the landing gear. He gained altitude and cycled the landing gear to the down position. The indicator showed two green lights for the main gear but no green light for the nose gear. The red light remained lit. The pilot cycled the landing gear again with the same results. Pilot made a request to the Tower to fly by the Tower at low level for them to observe our situation. We did and Tower said the nose wheel appeared to be only partially in the landing position. Pilot made a request to the tower to maneuver to the west of the airport and trouble shoot the problem. We moved to the west of the Redding Airport and reviewed the checklists to see if we could fix the problem. Pilot cycled the gear up and down two more times with the same results. After the last time, we noticed a noise coming from the nose wheel compartment. It sounded like something had come loose and was flapping against the fuselage. Pilot made a request to the Tower to make a low level fly-by. The tower said the nose gear was not fully extended, the nose wheel appeared to be cocked to one side, and he said it looked like a hose was loose in the nose wheel area. At this time, the Pilot decided to land the aircraft. He reviewed his checklist while I secured any loose items in the cockpit area. We were instructed to land on runway 30. As we flew over the end of runway 30, the Asst. Airport Manager, observed the nose wheel as we flew by. He said the nose wheel appeared to be only partially extended and slightly cocked to one side. Pilot did a great job landing the aircraft. Once the main landing gear was on the ground, he held the nose wheel off the ground for several seconds as he shut down the power and fuel. The nose wheel did not support the aircraft at all and we skidded approximately 100 yards to a full stop. At that time we exited the aircraft. This landing occurred at 1507. RASM comments: **The pilot demonstrated excellent airmanship throughout this incident. He put the aircraft on the ground safely and no one was injured. Communication was good, and notifications appropriate.** The aircraft is in the process of being repaired and the vendor will work with the Regional Aviation Maintenance Inspector on returning it to contract availability once that occurs. This incident is classified as an incident with potential.



SAFECOM 08-0726 - Aircraft was spooling up for bucket work mission when the mechanic noticed the tail rotor was not turning at normal speed as the main rotor he told the pilot to shut down. it was a failure of the hanger bearing. Parts have been ordered, when they arrive the part will be replaced and contact RAMI when maintenance is completed and test flight completed. RASM comments: The bearing was replaced and a test flight was completed. The RAMI was contacted and the aircraft returned to contract availability. This was a very good catch. The bearing experienced a total failure with relatively little time on it. The mechanic watching the spool up is to be commended for his attention to detail and effort at safety.

SAFECOM 08-0746 - While delivering a daisy chain of two blivets on a 150 foot longline, the pilot set the load down but was instructed to pick it back up and move it slightly downhill. During this maneuver the load started swinging and it hit a tree. Unbeknownst to the pilot, the long line and cargo hook wrapped around the tree three times. The ground personnel instructed the pilot to release the load as he was in a tree. The pilot released the load and the longline immediately unwrapped from the tree and the pilot departed the scene. This was the second load of the mission; the first two blivets were delivered without incident. A post-incident debriefing was conducted between the pilot, FAO, Fire IC and HMGB to review the details of the incident and lessons learned. FAO: The helibase this aircraft was assigned to included three other helicopters all performing initial attack and support on multiple lightning fires. This incident created an opportunity to refresh ground personnel, aviation managers and pilots on blivet delivery. The helibase manager worked with the helicopter pilots and helicopter managers assigned to develop a '6-minutes for Safety' style briefing on things to consider when ordering and receiving blivets. This included site selection and preparation (including specific challenges presented by the local terrain), line length, communication tips for providing good direction to the pilot and the effects of wind on performance. This briefing will be used as a tool to be discussed at helibase and district briefings at the first opportunity. Pilots were briefed on the importance of relaying operational problems to helicopter/helibase managers so every effort can be made to address hazards encountered--in this case, the pilot encountered challenging winds on the first load delivered. This could have been addressed by bringing the blivets in one at a time on the next load. RASM Comments: Very thorough follow-up and utilization of this occurrence to develop a specific 'briefing' for this mission profile. This demonstrates professionalism and commitment to safety through open discussion with all involved, resulting in variety of viewpoints and suggestions for improved performance.

SAFECOM 08-0699 - The helicopter was hauling a backhaul load of hose from a helispot on the Canyon Complex to the Quincy/Canyon Helibase. As the helicopter was approaching the helibase, the ABRO observed a steadily falling object fall from the load and land within two miles from the designated cargo area. Following the observation, the helibase manager and air support went in search of the lost item. Nothing was found from their attempts: however, a local brought one roll of butterflyed garden hose to the base after finding it in her yard. In the helibase debriefing, a AAR was performed on how to mitigate such incidences. The basics of loading and netting cargo were addressed and all persons involved understood the corrective actions as well as their importance. RASM Comment: Glad to see an AAR was conducted. FAR Part 133 requires, "Each flight must be conducted at an altitude, and on a route, that will allow a jettisonable external load to be released, and the rotorcraft landed, in an emergency without hazard to persons or property on the surface." Dropping a hose into someone's backyard may not be within this requirement. Helicopter managers continue to discuss external load operations with your pilot.

SAFECOM 08-0731 - Bucket and longline released from belly hook about a mile following departure from helibase enroute to fire. Prior to incident assignment Pilot {also a carded mechanic} had completed a 75 hour hook inspection on the belly hook. The pilot/mechanic had taken slack out of the manual release cable. Though all hook checks prior to mission departure were positive, the bucket and longline released. Pilot/mechanic loosened the manual release cable to allow the hook adequate freeplay within the hook housing on the belly of aircraft without tensioning the cable to the point of initiating release. Adjustment was ground tested and then followed by an airborne test under load. Aircraft and pilot conducted over 2 hours of longline missions following cable adjustment without further malfunction. To the pilot's credit he had followed standard operation procedures of avoiding flying over homes, highways, etc. and therefore the longline and bucket fell into a open hayfield. The pilot also took full responsibility for the incorrect adjustment of the manual release cable. FAO comments: All procedures followed, no further action. Excellent job by the Pilot for following procedures flying around congested area. RASM Comments: Concur with FAO comments.

SAFECOM 08-0727 - Pilot made the helicopter manager, the helibase manager, and the air support aware of a serious communication issue that occurred over the Siskiyou fire as the helicopter was transitioning to the Blue 2 fire for an aerial ignition operation. The pilot's statement to which the burn boss and PSD Operator both concurred follows. Helicopter NXXX called Siskiyou air attack who also had control of air space for the Blue 2 fire, for clearance to transition through the Siskiyou Complex to the Blue 2 fire. Air attack called back and said there was traffic in the area, but cleared the aircraft into the airspace. When helicopter NXXX got to their assigned division, helicopters were already working there and NXXX could not raise them on the victor radio. The pilot was called by Air attack who asked him who he was and what was his intended mission. The Air attack the pilot spoke to earlier was apparently from the Ukonom fire, not the Siskiyou. The Siskiyou Air attack lectured the pilot on how and when to call even though an Air attack cleared him into the fire area. When the pilot asked the Air attack if other helicopters were working on victor 119 or 132, he said they were on 132 because that is the area's frequency. The pilot still could not raise the other helicopters, so he tried 119 and the other helicopters responded. The pilot also stated that sometimes Air attack states which fire they are assigned to, but sometimes not. Due to the scanning mode of the radio, the pilot cannot differentiate which frequency the Air attacks are communicating on. The pilot nearly aborted the mission due to the lack of good communication with the aircraft working in the area. Prior to aborting the mission, HELCO came on scene and was able to restore good communications and NXXX continued with the PSD mission. Air support informed the AOBs in order to try and straighten out the communication problems and will have air operations convey to the Air attacks the need for clarity and precision when communicating and coordinating the air resources amongst fires within the complexes. RASM comments: This was a discussion item the STAT team addressed in their travels. **There have been a steady stream of communication issues especially with multiple incidents in the same general area. It is essential that folks identify who they are and what incident they are working; check TFR information for where they are flying; verify frequencies and locations. With the current level of aviation activities, we all need to do our part to ensure complexity and confusion do not create tragedy. If folks are not able to mitigate the communication risks, aborting the mission is the safest call. FAO: Good communication prior to the start of any mission is essential for all pilots, even if the communication has not changed from the day before, including relief!**

