



September SAFECOM Summary

USFS FOREST SERVICE AVIATION RISK MANAGEMENT



In memory of the flight crew and mechanic of T-09.
Our thoughts and prayers go out to family, friends and co-workers.

SAFECOM Statistics

Agency	FY08	Ave
All	965	1,077
USFS	594	714
DOI	254	353
State	108	54
Other	9	22

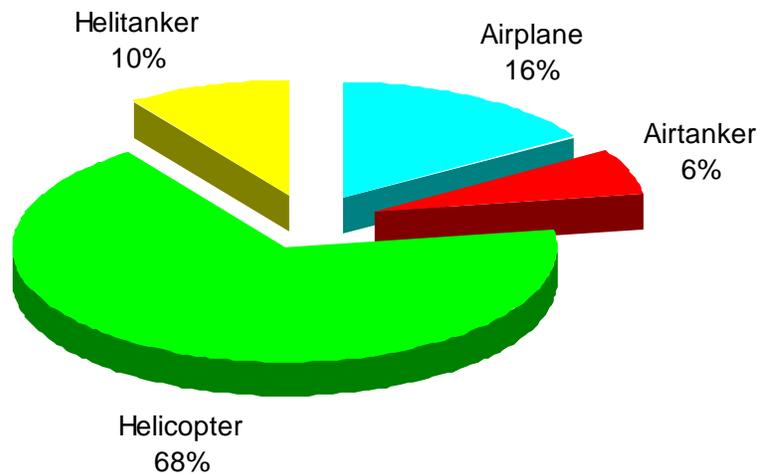


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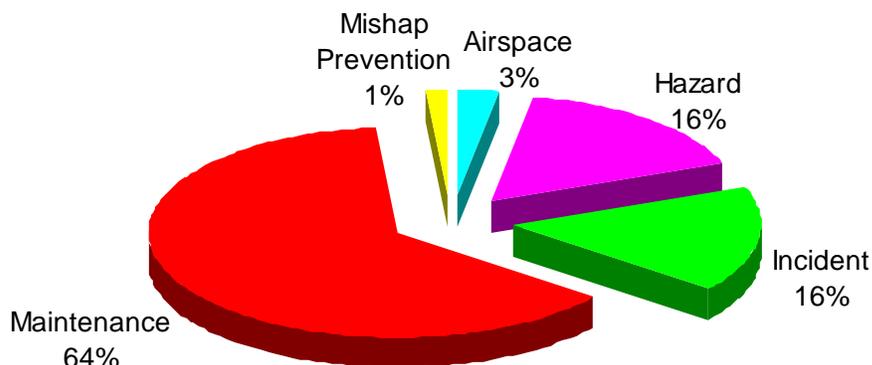
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SAFECOMS by Aircraft Type

Aviation activity slowed down considerably in September as did the number of SAFECOM reports. For the month of September there were 84 total SAFECOMs reported, of which 62 were USFS. This was below the USFS 10-year average of 79. Of the 62 USFS SAFECOMs; 10 were for fixed-wing, 4 for airtankers, 42 for helicopters, and 6 for helitankers.



SAFECOMS by Category



ACCIDENT— The USFS had no accidents in September. We did participate in the T-09 accident investigation since it is a USFS contract. See NTSB report below.

NTSB Identification: **SEA08GA194**

14 CFR Public Use

Accident occurred Monday, September 01, 2008 in Reno, NV

Aircraft: Lockheed SP-2H, registration: N4235T

Injuries: 3 Fatal.

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 September 1, 2008, about 1810 Pacific daylight time, N4235T, a Lockheed SP-2H airplane, was destroyed after impacting terrain following a loss of power and loss of control about 2 miles northwest of the Reno/Stead (4SD) Airport, Reno, Nevada. The airplane was registered to Neptune Aviation Services Inc., of Missoula, Montana, and operated by the California Department of Forestry and Fire Protection (CAL FIRE). The airline transport first pilot, who occupied the left crew seat, the airline transport second pilot who occupied the right crew seat, and the flight mechanic who occupied the cockpit jumpseat, were killed. Visual meteorological conditions prevailed for the Public Use air drop flight, which was being operated in accordance with 14 Code of Federal Regulations Part 137, and a company flight plan was filed and activated. The flight was originating at the time of the accident.

An air tanker base employee who witnessed the accident reported observing the airplane taxi to Runway 32 "...and everything appeared normal." The witness reported watching the airplane takeoff, and at an elevation estimated to be between 100 to 300 feet above the ground, he observed the left jet engine emitting flames, followed by the left wing being engulfed in flames. The witness further reported that about 2 seconds later the airplane entered a left wing down attitude before impacting terrain and bursting into flames.

The National Transportation Safety Board investigator-in-charge (IIC), accompanied by representatives from the Federal Aviation Administration (FAA), the United States Department of Forestry, and representatives from Neptune Aviation Services, Inc., responded to the accident site on September 2, 2008. The initial onsite examination revealed that about 500 feet from the departure end of Runway 32, several identifiable pieces of the airplane's left jet engine were located. It was also revealed that prior to impacting terrain the airplane had collided with a set of powerlines, estimated to be about 50 feet high. An initial ground impact scar was observed about 25 feet west of the powerlines, followed by the airplane's energy path proceeding in a westerly direction, covering a measured distance of about 755 feet on a magnetic heading of 250 degrees. The damage assessment also revealed that the airplane had sustained significant fragmentation and thermal damage throughout the debris path.

SAFECOMs by Category continued



"I was always afraid of dying. Always. It was my fear that made me learn everything I could about my airplane and my emergency equipment, and kept me flying respectful of my machine and always alert in the cockpit."

Chuck Yeager

AIRSPACE — The good news is, there were only two Airspace SAFECOMs reported, one intrusion and one conflict.

HAZARD — There were 12 hazard reports, 4 regarding communications, 4 on pilot action, 3 on policy deviations and one preflight action. While the last few months we saw about half of the reports in this category related to communications, they were about half of what is generally reported.

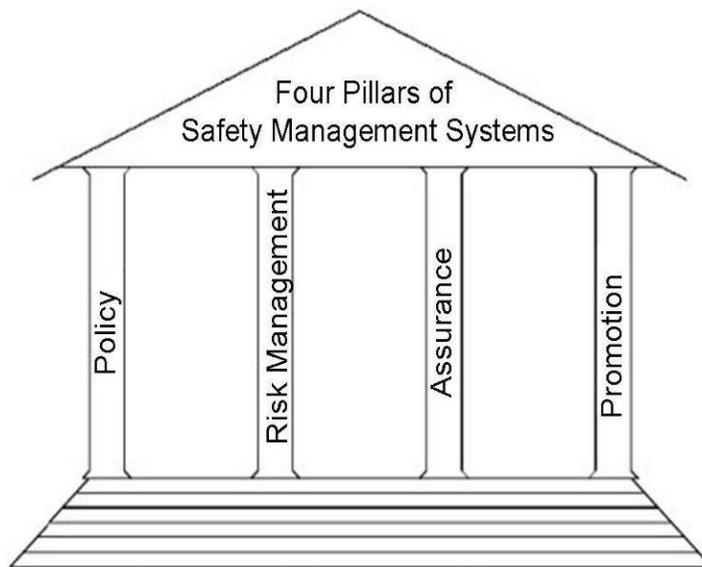
INCIDENT— There were 12 incident reports, and not one dropped load reported, however, there were 4 dragged loads. There were 4 precautionary landings due to mechanical issues, one security issue and 3 categorized as other.

MAINTENANCE — Forty-six of the reports submitted (64%) were maintenance related. This is a much higher percent than usual, generally about half of the SAFECOMs are maintenance issues. Electrical problems were the most reported (15) which is very unusual as engine and chip lights are usually the most reported. There were only 6 engine and 4 chip lights reported.

MANAGEMENT—There was one management SAFECOM having to do with a helicopter ordered on an incident by a private organization.

MISHAP PREVENTION— There was only one categorized as such, but once again there were actually a few more that easily could have been.

Safety Management Systems (SMS) Pillars



POLICY—All management systems must define policies, procedures, and organizational structures to accomplish their goals.

RISK MANAGEMENT—A formal system of hazard identification, analysis and risk management is essential in controlling risk to acceptable levels.

SAFETY ASSURANCE—Once controls are identified, the SMS must ensure they are continuously practiced and continue to be effective in a changing environment.

PROMOTION—The organization must promote safety as a core value with practices that support a positive safety culture.

SAFECOM 08-0960 - The purpose of the SAFECOM is to document a situation that occurred over a fire located next to the Big Sky Resort. The Jurisdiction for wildland fire suppression is the responsibility of the USFS even though there is no public land being protected (protection responsibility is established via an inter-agency protection agreement). The fire was started by private individual burning piles {golf course manager}. The FS was notified of incident at around 1600 after the county had made initial report to their dispatch. Fire was reported to be 10 to 20 acres in a Subdivision. At 1630 I was launched as an ATGS to provide aerial supervision. The forest ordered a type III CWN aircraft and a State Helicopter to respond. When I arrived both Helicopters had just gotten on scene as well. We set up ground contacts, traffic patterns into the dip site {Golf Course Pond} and drop patterns. At 1730 I received a heads up that an additional aircraft was enroute ordered by the Golf Course Manager directly to the company {they were and are going to be paid by the private entity}. At this point I requested to dispatch that we try to find out who was coming. 1750 I was notified the helicopter was a K-max and that they had been given the A/G and A/A frequencies. They arrived on scene at 1800-- fortunately the pilot and aircraft were agency carded and familiar with FTA. They contacted us on frequency and we put them into the mix. This situation worked out because the other two helicopters were returning to their fuel trucks at the time the Kmax arrived. The K-max pilot made it very clear they were not working for the FS but for the private land owner. That being said we worked with the Kmax and operations were conducted safely. The issue in this scenario is the ordering of aircraft by private entities to respond to a fire that is under the protection responsibility of the Forest Service without an attempt by the land owners to coordinate the effort. In this case, the Fire Chief for Big Sky happened to overhear the property owner order the helicopter via a phone call and he gave us the heads up. This could have been a different scenario which could have resulted in a helicopter arriving over the fire unannounced without proper communication. The fact that we got them the frequencies was very lucky. The Big Sky area is unique in regards to the amount of wealth of the residents and their subsequent willingness to order and pay for resources themselves. This is a situation the forest has identified and is currently working on a solution. FAO Comments: Protection for this area falls under what is referred to as a 6-Party Agreement. This six party agreement made sense when the lands were undeveloped. Since the inception of the six party agreement the Big sky area has seen heavy development with multi million dollar home and resorts across a once forested landscape. The key to this not being a major incident is the fact that the Forest Dispatch ground forces and ATGS were communicating well and once it was discovered that a private landowner decided to acquire their own aerial resources, we were able to locate who was coming and then contact them and get them the correct frequencies. The aircraft that arrived has a CWN contract with the FS and the pilot has been carded for fire operations in the past. They are not currently carded due to the contracting process being delayed in 2008. They will be for the 2009 fire season. When we mobilize aerial resources to respond to the area all aerial resources will be briefed on the potential for unassigned aircraft showing up to work the incident. Everybody did a good job staying focused on safety. RASM Comments: This type of situation is likely to occur in other places due to ongoing, and increasingly common development in WUI areas. It may not be all that unusual to have private landowners try to acquire aerial resources to help protect their property. While this situation is more of a fire protection agreement issue, that the unit is now working to resolve, it serves as a good example of an `unexpected` aircraft entering the airspace, and for reasons that we may not be fully aware of. In this case, the ATGS was able to obtain critical information about the helicopter that had been ordered by the landowners, and the Dispatch Center was able to provide correct frequencies to that resource. The ATGS did the appropriate risk assessment and determined that operations could continue in a safe manner due to the private aircraft having correct frequencies and experience in the Fire Traffic Area. ATGS stated that he would have `dis-engaged` had this not been the case. This occurrence serves as a good reminder to always practice `see and avoid`.

SAFECOM 08-0957 - Helicopter was dropping water on the Gnarl Fire with bucket attached to a 150 ft. long line and was requested to make a spot drop on a hot area down in a steep drainage. While lowering the bucket to get over the spot for the drop, the bucket swung out and contacted a tree on the slope briefly and then swung free. The pilot proceeded to lift out of the area after the drop and no harm was done to the bucket. Helicopter Manager talked with Pilot about this incident and pilot agreed that he would not get too low or below tree top level with bucket again. It was agreed by all that this is an especially important watch out situation when trying to make a spot drop in a steep, narrow canyon where timber on the slope may come within close proximity to the bucket. RASM Comment: Good risk management..... good job; thanks.

SAFECOM 08-0954 - T-xx Departed the airbase for the Fire. At rotation the {#}1 Recip fire warning light came on. Power was reduced to METO on both the Jets and Recips. The light went out and all cockpit gages read normal. The A/C was turned into a left downwind and the tanker base was called and asked to look for any sign of smoke or fire on the left side of the A/C. The tanker base reported no sign of fire on the A/C and we continued our left traffic pattern and used the jettison area to get rid of the retardant. We then made a normal landing without incident. The {#}1 PRT was found to be leaking exhaust gas on a fire loop. R&R {#}1 PRT, test flight, back in service. Submitters Comments: Lessons learned: Every flight is a training flight. Use every chance you get to review your standard and emergency procedures. MAKE the time during normal operations. "FLY THE AIRPLANE". Don't let an incident turn into an emergency. Use your check list and diagnose the problem after you, All Together Now "FLY THE AIRPLANE". Changed the PRT. RASM Comments: Well done on the flight and well said on the corrective actions.....

SAFECOM 08-0952 - Dipsite Manager Comment: On 9/27 at the dipsite I observed the helicopter carrying out bucket operations. At 17:00 the helicopter returned after fueling to the dipsite. I noted that the helicopter dumped it's first bucket back into the lake due to lack of altitude. At 17:08 the helicopter was lifting out of the dipsite and broke off the top of a tree with the bucket. He dumped the water and returned to refill. The bucket did not appear to have any damage, and the ship was not affected. Pilot Comment: After lifting a bucket from Lake I noticed a torque split and slight loss of power on take-off. While directing my attention to the power problem the bucket contacted a tree during take-off. After the take-off I determined that one throttle was not fully open. I discharged the water, corrected the problem and came around to refill the bucket then resumed water drop operations. After discussing with the pilot we determined adding an additional 50 feet of line and cinching the bucket by 10{ } should offer a wider safety margin. UAO comments: I contacted the Helibase and reminded Base Manager that all maintenance related issues needed to be brought to the attention of the R6 Maintenance Inspector and not solely the AMI for the Region they are from. Helibase Manager promised to pass this along to the Helicopter Manager and remind all Managers at tonight's debriefing that it is standard practice to make contact with AMI in the Region you are working or the event occurs and not solely with the Region for which you are from. AMI comments: This maintenance office was never contacted about this issue..

SAFECOM 08-0934 - The Fuel Truck Driver fueled the helicopter at the Airport at the start of the day. We then flew from Lufkin to Pineland Airport. Next we flew a recon mission for 1.5 hours that took off and landed at the Pineland Airport. After the helicopter landed, the helitack crew noticed the fuel cap was unlatched and open, but was still connected to the helicopter by the hinge. The pilot, manager, crewmembers and fuel truck driver talked about how the fuel cap latches the correct way. The fuel truck driver will be sure the fuel cap is latched correctly after fueling. The pilot and manager will perform a more exact preflight walk-around looking not only to see if the fuel cap is closed, but also latched correctly. RASM note: Education through experience!



SAFECOM 08-0947 - Sept 26-2008 helicopter was supporting Rattle fire. 1ST cycle of the day and on fire, when requested to division Oscar by incident air attack for bucket work. Working with another Kmax in a daisy chain and communication back and forth the conversation was about the smoke conditions. After being into the drop site 2 times already we determining that it was VFR conditions suitable for both aircraft, when I went into the drop site to show him the location of the drop site. After my drop was successful the other Kmax came out of the dipsite towards the drop site to start his turn. I went into the dipsite and after coming out I watched his approach into the drop point. After he was successful in his attempt I went after him following his approach pattern. As I headed closer to my drop point the visibility was good and proceeded to into the drop point. As I got closer to the drop point I still had good visibility in front of me and off to my left hand side bubble window. A large column of smoke came in on the right side of the aircraft, at which time I lost all vertical reference. A thermal updraft took me upwards quickly while visual reference was lost. Knowing people were below me I decided not to punch off the load, and pulled up on the collective as to gain altitude so I wouldn't come in contact with the ground or other hills when I suddenly felt the helicopter in a upward spin to the left and became weightless in the seat. Not knowing which way was up, down or sideways I dropped my load of water and was about to eject the bucket when I came out of the clouds spinning counter clockwise and nose pointing towards the ground. Having enough altitude and regaining visual reference I was able to pull out of the spin and level the nose of the aircraft. Contacted Air attack and told him I was heading back to base. Approximate time in smoke 5 seconds. UAO comments: This was an unexpected event. Pilot is recognized for the honest reporting and sharing this experience.

SAFECOM 08-0939 - While going into the dip the pilots experienced rapid settling with power as the bucket was being put into the water. The dip-site managers say aircraft was approximately 40 feet off the surface when settling ceased. Aircraft was equipped with 150 foot long line and a FAST {Fire Attack Storm Tank} Bucket. PIC made decision to jettison bucket and longline in order to pull out of the dip-site. Aircraft returned to helibase without incident and no damage occurred to aircraft, bucket or longline. ASGS notified local unit aviation officer. Manager notified Region 6 and 1 Maintenance Inspectors. No corrective action. AOB, ASGS, ASGS{t} and HEB1 all concur that the safe decision was made in regards to jettisoning the external load. Retrieval of bucket and longline at vendor's expense coordinated by company with fire air operations and local unit aviation officer and resource advisors. UAO comments: ASGS did contact me about the incident approximately 15 min after it occurred, however details on the severity of the event were not relayed to the HEB1, ASGS or I until the SAFECOM was written. Further discussions are on-going. RASM Comment: Settling-With-Power is a serious condition so follow-up becomes very important to reduce the possibility of reoccurrence. The R6 Helicopter Operation Specialist (HOS) and the R6 Helicopter Inspector Pilot (HIP) were both contacted and asked to investigate. The HIP contacted the vendor's Chief Pilot to discuss the event and the HOS contacted the field crew. The following are their discoveries:

- The pilot flying the helicopter at the time was a trainee PIC.
- Both pilot(s) recognized the settling-with-power condition before the bucket hit the water.
- The PIC moved the helicopter approximately 60-70 feet to one side to gain clean air; this is standard procedure in a settling-with-power condition.
- One of the pilots released the longline and bucket.
- The pilots were able to arrest their descent and fly away.

Corrective Action taken by the vendor:

- Pilots will be instructed by the company on recognizing settling-with-power, the procedures to prevent settling-with-power, and the techniques to exit the conditions and arrest descent if they get into settling-with-power.

SAFECOM 08-0933 - At approx 0800 the pilot initiated a start sequence for a ferry flight. After the starter was initiated it quickly died off and no power was present. The pilot visually checked the battery and cables and checked for power again. The loss of power was discussed and the original thought was that the helicopter had been sitting in cold conditions for the past three days and that the battery was simply dead. After hooking up the APU the pilot was able to successfully start the helicopter and run all preflight checks including a check of the volts meter which read 27.5 {a normal reading for this aircraft}. The load meter was also double checked and indicated normal operating range. After landing and shutting down the pilot again checked for power, with no power indicated he notified me that the helicopter would not start and he would call for a mechanic. The Mechanics inspection revealed that the battery cable from the disconnect to the relay had cracked thus producing an intermittent power supply. He replaced the battery cable and returned it back to service. The appropriate phone calls were made and the Helicopter was later returned back to contract availability by the R1 Maintenance Inspector. Discussion with the owner and the primary pilot has led us to believe the battery lock out mechanism {manufactured by DART} required to be used on this contract forces the installer to flex the cables when being attached or detached from the battery thus after causing the interior portion of the cable to weaken due to constant flexing and metal fatigue. Flight crew had an open discussion and training on how to minimize flexing of cables when attaching and detaching the battery lock out device. FAO comment: Discussion with Manager, all SOP's followed. Good job identifying and bringing the issue with the locking mechanism to light. Others using this type of locking mechanism may want to check the cables. No further action taken. RASM comments: Good job of describing the problem in the narrative, so that it is well understood by all. Appropriate actions taken, aircraft returned to contract availability by RAMI.

SAFECOM 08-0927 - Pilot reported during bucket operations with a 75 foot longline on the 18th. drop empty bucket made contact with the top few feet of a 100 foot plus conifer. The incident took place about 30 yards from the fire. The bucket was accessed at the dip site and it was determined to be fully functional. The fuel cycle was completed with 6 additional bucket drops. The pilot stated visibility was not a factor. A different target was requested resulting in a change to the previous bucket drops approach and departure path. Submitters comments: Pilot stated subsequent target locations were evaluated more thoroughly for sufficient approach and departure clearance prior to commencing bucket operations. R5 RASM Comments: Good risk management and Pilot decision making is critical for safe operations.

SAFECOM 08-0918 - The Airtanker took off from Redmond Airport but shortly after take-off the Airtanker could not retract its landing gear. The Airtanker informed the Tanker Base, and requested the Lat/Long for jettison site. The Airtanker flew to the designated jettison area and dropped its load of retardant. The Airtanker maintained communications with the Redmond Airport Tower, and they cleared the way for the Airtanker to land. The landing was uneventful. Later it was learned, that there may have been a loss of hydraulic fluid? The Airtanker did an excellent job of communicating his situation with both the tanker base and the airport Tower. The retardant was dropped in a safe location, and precautions were taken by the airport to help ensure a safe landing. AMI comments: All procedures followed, Main Landing Gear Selector Valve R&R'd and aircraft returned to contract availability. Good job.

SAFECOM 08-0904 - Sometime during the last water dropping mission of the day, the window on the cargo door became separated from the door and was lost. This occurrence was discovered when the helicopter landed at the helibase. Since the window was not found, the actual cause of the window loss is unknown. Submitters Comments: A new window was put in place, clips, and window release handle inspected. RASM Comments: Checked with submitter of the SAFECOM and made sure that the rotor systems and aircraft were thoroughly examined for any possible damage that could have been caused by the departing window. This window and its attaching system will be regularly checked.

SAFECOM 08-0924 – Aircraft was ordered up with a bucket. The Helicopter is equipped with a fixed tank under the exclusive-use National Helicopter contract and within section B-12 is necessary to have a variable capacity collapsible bucket as an addition or back-up. The helicopter has a FAST {Fire Attack Storm Tank} Bucket, manufactured by Absolute Fire Solutions, INC and distributed by Simplex MFG. While making a dip at the dip site, one of the purse string wires hooked underneath the bolts rubber stopper and nut on the metal frame; this resulting in the frame bending under the added stress to the frame itself rather than the anchor points as intended. The frame was bent in a twisting manor and the purse string wire had grooves {ware} along it showing that it caught on "something" with an edge. The pilot brought the helicopter back to the helibase after noticing an issue with the bucket {2nd dip of 3rd fuel cycle}. The base was notified of the helicopters return and predicament. The mechanics removed the bent, twisted, partition of the frame to apply heat in order to straighten the partition back out. The corrected partition was replaced back on to the frame itself so the bucket would be operational. It was then noticed what caused the problem and a solution was made to flip the frame {each partition}, so that the bolt heads were underneath and the stopper and nuts were on top. This mitigation would then prevent the wires from catching on the frame causing the additional stress to the frame of the bucket when being picked out of the dip. This has been a reoccurrence for another helicopter at the same helibase and fire that also utilized a FAST Bucket as its primary bucket. It is believed that the same incident happened to theirs as well. RAMI comments: Mechanic notified FAST Bucket manufacture and applied approved repair to bent frame. The mechanic also notified manufacture that this is a common occurrence with these buckets. AMI recommends an Information Letter be generated for issues with FAST Buckets. All procedures were followed. RASM Comment: All this information plus pictures was sent to the National Aviation Safety Center with a recommendation to send out a Technical Bulletin on these buckets. NASC Comment: Simplex was notified of the problem and they will issue a technical bulletin with a recommended fix, which will be distributed by the NASC.



Bent Frame



Original



Modified

SAFECOM 08-0910 - While working the fire with longline-bucket, Copter Nyyyyyy contacted a 15" snag with the bucket while exiting the dip site. The snag dislodged from the base and became entangled in the bucket's webbing. The pilot released the water and tried unsuccessfully to untangle the snag . The Pilot flew back to helibase with the snag attached to the bucket. Submitters Comments: Discussions were held about visibility and approach/departure of the dip site and deemed acceptable. The availability of ground personnel for assistance at the fire was also discussed. RASM Comments: I went up to discuss this incident with the pilot and was able to look at the snag that had been entangled, but the pilot was not at the base. Follow-up: Personal conversation with the pilot on the importance of keeping a safe distance from obstacles. I also discussed with the pilot risk management concerns about flying the bucket with the snag still entangled in the lines all the way back to the helibase. His reasons for doing this and the risk assessment that he went through mentally at the time made sense and we left it at the fact that there are a number of ways to assess risk and different alternatives that can be utilized. As the PIC, he is the one that has to choose the correct action and I just wanted to make sure that he knew that there were other alternatives available.

SAFECOM 08-0914 - While conducting a helitorch burn, an experimental nozzle tip manufactured by MTDC was used on the Spec 2000. This tip was installed in coordination with MTDC Reps and Forest Aviation personnel to test its performance. It was to provide a heavy and thick flow: to spread like a star. Pilot was informed that the tip was experimental and had not yet been tested, and MTDC would be seeking his input with regard to its performance. Flew to the unit to burn with the test tip for the torch, the following performance issues were noted: while over the burn at about 15kts, the first attempt to ignite the torch resulted in a very wide burn spray pattern very close to the tip. Pilot adjusted airspeed by slowing to 4-5 knots, to determine if performance of the tip was poor due to high airspeed-- attempted a second ignition at about 4-5kts, which resulted in a fine mist from the tip with a wide diameter spread of gel {much like a garden spray)--this resulted in the arm, tubing, and housing of the helitorch becoming coated with gel. The gel coating the arm tubing and housing then ignited, resulting in a 5 to 6 foot fire ball that rose from the tip vertically up towards the helicopter. Pilot then stopped ignition. Increased air speed, and noticed the gel coated area flamed out after 4-6 seconds. With all fire out pilot returned to Helibase with torch. He informed the Helibase and burn boss of the problem. FAO: Again, this was a tip that MTDC asked to be tested. The pilot made the appropriate decision to conclude the burn and get the tip replaced. MTDC will be briefed on the situation. All operations after the tip was replaced were normal. RASM comments: FAO is working directly with MTDC on this issue and returned the faulty tip to MTDC for inspection. More information is forthcoming as it becomes available from MTDC.

SAFECOM 08-0900 - At 19:22, the helicopter was requested for a medevac on Div. A; on the Rattle fire. At 19:29, the helicopter departed helibase for Div A with 3 helitack and 1 Paramedic on board. While traveling to the scene additional information from helibase was provided indicating that the patient had been struck by a snag and had been unconscious. Further instruction was also given to deliver the patient directly to Roseburg Airport to transfer care to an ambulance. At 19:43, the helicopter had landed at the designated medevac LZ on Div. A. Shortly afterwards the patient was loaded and the helicopter departed the LZ for Roseburg. The helicopter landed at Roseburg Airport at 20:27 and transferred the patient to the awaiting ambulance. The helicopter manager and the pilot discussed flying under this limited daylight condition and the pilot was comfortable doing so. The helicopter landed 24 minutes after the designated shut-down or "pumpkin" time for the aircraft. The risk associated with doing this was mitigated by landing at the lighted airport in Roseburg. After weighing the severity of the injury and alternative transport options against the risk of breaking pumpkin time, it was determined that landing at Roseburg with the patient was the best course of action. Due to the unpredictability of the medical incident and the severity of the injury; little could have been done, given available resources, to improve upon what occurred. Given additional resources we could utilize medevac aircraft capable of flying at night. UAO comments: Principles and procedure of risk management were applied and on a continuum assessment. RASM Comment: Great risk management by the crew.

SAFECOM 08-0891 - During pre-flight inspection, conducted by pilot and mechanic, an area of delamination was discovered on one of the tail rotor blades. The area measured approximately 3" X 4". The area exceeded the manufacturer's limit and the mechanic put the aircraft out of service. Submitter Comments: The company ordered a replacement part from their home office that was delivered early the next morning. Tail rotor segment was removed and replaced with the replacement part. The tail rotor was balanced as per maintenance manual specifications. Company did a ground run up and then performed a 25 minute test flight. Mechanic returned the aircraft to service. R-5 maintenance was contacted and all necessary documentation was FAXed to NZ air unit. Maintenance inspector returned the aircraft to availability. FAO Comments: I believe that a positive contributor to identifying the delaminated tail rotor blade was a thorough walk around that was conducted prior to a mission. Good Catch!



SAFECOM 08-0897 - On Sept 2nd, at 1615, The FHP survey flight ended our survey day in Wenatchee. We noticed some new barricades and gates at the airport, new from a couple of week previous when we had stopped at EAT for lunch. I walked along the fence looking for a pedestrian gate. When I didn't find a gate I walked into fire warehouse and was guided to the dispatch center. I was given a gate code so I could drive out and pickup the rest of the crew and our luggage. Took care of the business in dispatch and went into town for the evening. On Sept 3rd, after dropping the pilot off at the plane, I went into CWICC to make flight following arrangements for the day's survey. After making arrangements with CWICC for flight following I headed out to the aircraft. I went out the way that I had come in, through the warehouse. I walked through the warehouse and out toward the plane. Then I heard someone ask if they could help me. I replied that I didn't need help because I was just going to our plane. Then I was notified that it was inappropriate to walk through the warehouse to access the plane and that I needed to use one of the gates; also that new security procedures were in place at the airport, and if they weren't followed that the FAA could impose fines. I explained that I was a FS employee, and that I came in on an airplane and needed to get back to it, and that I wouldn't use the warehouse as a path to get to the dispatch center. Departed EAT at 928. This incident brings up a couple of communication/security issues. First is that the security level at EAT had changed, and that this information was not communicated through agency channels as it affects agency aviation operations. Second, the new procedures for accessing the dispatch center from the aircraft tie-down area should be communicated to flight crews that are over-nighting in Wenatchee. I would suggest that CWICC put together a handout that they could share with flight crews that are unfamiliar with the restrictions of the new security requirements at EAT. RASM Comment: The heightened airport security has made it inconvenient for everywhere to access the runway area. The FBO is an alternate route but again it is not convenient. We will continue to ask for a person gate close to the warehouse. FHP UAO Comments: Confusion over new security measures was experienced on 9/2/08. `Security Changes` memo mailed on 9/11/08 was useful. SAFECOM used as an avenue to stress timely communication. Violations of security protocols could be serious.

SAFECOM 08-0894 - Helicopter left Hope Airport with and external load on 100 ft. line. The load was a fish tote containing survival gear weighing approx. 350{#}s. Hope airport is a small 2000" dirt strip runway 1 mile SE of Hope Alaska {a small remote town, population around 150}. At about 2 miles from the staging site, the long line came off the cargo hook and the line and load fell straight down into a wooded area with no structures, roads or people. The pilot came back and got the helicopter manager at the staging area and went to mark the load with GPS coordinates and located a landing spot where the manager and one other FS employee could walk through the woods about 20 minutes to the load. Helicopter returned to base and had the hook checked out. Nothing was found wrong with the hook. Helicopter returned the next day with a 150" line. The manager and other employee walked into the load from the spot located the previous day and re-hooked the load. The load was slung back to the airport. The tote was damaged so another tote was used to sling the gear to Hope Mountain. The mission was completed without further incident. Still unclear why the line came off the hook. Pilot said he performed a hook test before lifting the load and may not have recycled the hook properly. The load did not come off until over 5 minutes into the flight. The company checked the hook after the incident and found no problems SAFECOM should have been filed in a more timely manner. RAMI COMMENTS: The hook was inspected, the mech. didn't find anything wrong. Will talk to the company to follow up on the hook. RASM Comments: No further action needed.

