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Flightfax®

Online Report of Army Aircraft Mishaps

This issue is our half-year review of Fiscal Year 2012 aircraft accidents. The stats for the first half of the year begin on page 2. BLUF: We could be on a difficult glide slope.

Investigation board observations from a recent accident continue to spotlight consistent deficiencies, causing an undesirable accident trend for this year:

- The crew was complacent in the execution of a simple mission. The crew allowed the aircraft to enter into and continue an uncorrected rapid rate descent until it was too late to recover.
- ACT-E: There was a systemic problem with the unit not conducting the annual sustainment training. The board suspected the unit's lack of ACT-E sustainment training contributed to the accident.
- The mission briefing officer (MBO) signed he had verified that a performance planning card had been completed, the reading file for crewmembers was current, OGE was available, survival radios were on hand, and ALSE was current for crewmembers. The MBO took the PC's word that these things were correct. Discrepancies were found in each of these areas. The MBO has the responsibility to ensure crewmembers comply with the mission briefing checklist.

Our most pressing issue continues to be the 94% result of human error, of which there are many causes. In the last three issues of Flightfax, we've covered topics of which indiscipline and poor quality mission briefings are primarily to blame for the human error accidents reported thus far in FY12. No doubt, these trends are reversible, but we need to get on it NOW before more catastrophic accidents happen. Reversing this year's trend will require Aviation commanders, Leaders and trainers to place special emphasis on the following three critical issues.

First, Aviation Leaders must reinforce a command climate of accountability. Violations of regulations and procedures must never be tolerated, no matter how well liked an aviator may be within the unit or chain of command. Second, all Leaders should review their unit's three-step mission approval process. Recent investigations show a breakdown in step two, specifically regarding mission planning and briefing, which requires personal communication and interaction to ensure understanding of all elements involved in the flight. Lastly, Leaders should review how they conduct training for mission briefing officers and final mission approval authorities. Mission briefing officers are the eyes and ears who ensure the commander's risk management program is followed to the letter, so Leaders must take the time for periodical over-the-shoulder reviews to ensure mission briefers are adequately meeting their responsibilities.

Army Safe is Army Strong!

BG William T. Wolf, Commander, USACR/Safety Center

Preliminary Report on 1st Half FY12 aircraft accidents

In the **manned aircraft** category, Army aviation experienced 10 Class A - C aircraft accidents this fiscal year. These accidents resulted in five fatalities. Ten of the accidents were Class A's, seven were Class B's, and 44 were Class C's. For comparison, the first half of FY11 had 52 Class A – C aircraft accidents - five Class A's, six Class B's, and 41 Class C's with 4 fatalities.

For the first half of FY12, all 10 of the Class A mishaps and six of the seven Class B mishaps were the result of human error (94%). Nine of the 17 Class A and B mishaps occurred at night. Materiel failure or suspected materiel failure was contributing in one of the Class B's (engine high-side failure) and six of the 44 Class C's. There were two Class C bird strikes reported. Eleven of the 17 Class A and B mishaps occurred in OEF.

Dust landings were contributing factors in two Class A's and four Class C aircraft mishaps. Additionally, there were three (one Class A, two Class C) UH-60 ground taxi mishaps, three aerostat tether strikes (two Class B, one Class C), and two Class A mishaps resulting from operating main rotors striking personnel while conducting passenger on/off load operations.

Breakdown by aircraft type:

	Class A	Class B	Class C
UH/MH-60	3	0	15
AH-64	3	3	5
CH/MH-47	2	1	7
OH-58D	1	0	8
LUH-72	0	0	1
TH-67/OH-58A/C	0	2	3
AH/MH-6	0	1	2
UH-1H	0	0	0
C-12	0	0	3
EO-5C	1	0	0
Total	10	7	44

Synopsis of selected Class A accidents (OCT – MAR 12) are listed on the next page. (N/NVD) denotes night/night vision device mission:

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Manned Class A

-HH-60M (NVG). While conducting patient evacuation during a two-wheel pinnacle landing, an aircrew medic came in contact with the operating aircraft main rotor system. The Soldier suffered a fatal head injury.

-CH-47D (NVG). The aircraft landed hard in dust conditions, sustaining damage to the landing gear, airframe and main rotor.

-UH-60L. The aircraft tail rotor struck a concrete barrier during ground taxi to parking. The tail rotor assembly was severed.

-OH-58D (NVG). Two OH-58Ds on separate NVG RL progression training flights in the local training area collided in mid-air, resulting in four fatalities.

-AH-64D (NVS). A break in the drive train occurred, resulting in loss of tail rotor authority. The aircraft contacted the ground and rolled onto its left side.

-UH-60L (NVG). The aircraft was conducting a pinnacle, single-wheel landing for exfil of passengers when a local national interpreter was struck in the head by the main rotor blades resulting in severe injury.

-CH-47F (NVG). The aircraft crashed on short final during environmental training after the forward main rotor system contacted rising terrain. Crash caused extensive damage.

-EO-5C. The aircraft landed with gear up during emergency procedure training.

-AH-64D. During post-mission flight demonstration maneuver, the aircraft contacted the ground and was destroyed in subsequent crash sequence. Two injuries.

-AH-64D. During an aborted take-off maneuver, the aircraft descended and impacted the ground. The main rotor system contacted the canopy, injuring the front-seat pilot. The aircraft was destroyed.

In the **unmanned aircraft systems** for the first half FY12, we experienced 24 Class A–C incidents with two Class A's, seven Class B's, and 15 Class C's. The Class A's included one MQ-5B Hunter and one MQ-1 Warrior. FY11 had 34 mishaps for the same time period. FY12 Class B's consisted of five RQ-7B Shadows, one MQ-5B Hunter, and one Aerostat balloon that was struck by lightning. Of the 15 UAS Class C category mishaps, there were – nine RQ-7s, two MQ-1s, one Silver Fox, and three Puma's. Of the 24 total UAS Class A-C mishaps, 14 were RQ-7B Shadows. The predominant cause factor for Shadow mishaps was engine malfunction.

Synopsis of selected accidents (OCT – MAR 12):

UAS Class A

-MQ-5B. The nose wheel collapsed during landing and the UA swerved and came to rest off the runway with damage.

-MQ-1C. The UA exhibited low oil temp and pressure indications accompanied by manifold temperature spikes. The crew lost link as system was returning to base. Radar coverage was subsequently lost and UA not yet recovered.

Gun Pilot Rules for Survival

CW5 Gregory R. Turberville
Directorate of Evaluation and Standardization
U.S. Army Aviation Center of Excellence
Fort Rucker, AL

Army Aviation has one of the best safety and standards-based training and execution records of any military program. From an aircrew member's first day in accession through his/her last flight on active duty, they are constantly trained to be disciplined, vigilant, responsible for their actions, and abide by established regulations. Each rule, regulation, limitation, emergency procedure (EP), cockpit and mission task is rehearsed, enforced and re-enforced countless times over the course of an aviator's career. All the rehearsals, attention to detail and adherence to standards have proven effective in mitigating countless incidents and provided salvation in otherwise risky situations.

Noting this, I've developed a personal set of rules that I've shared with units and crews in training over the past several years. My rules are intended to enhance or close the gap for the programs already in use within the aviation community. One of the challenges we have is that the human element regarding judgment, maturity or decision-making is often removed with the way we memorize and rehearse elements, such as EPs and limits within our own specific mission design series (MDS). The task is purely rote and mechanical with little development of the process prior to, during and following events or tasks.

We see individual aviators who can memorize and recall tasks, specifics and numbers with perfection and others who struggle with the basics. Yet within this range of performance, each individual still must maintain an essential element of "what if?" and consider the subsequent effects of each cockpit/crew/mission decision whether in extremely dynamic combat situations or even the most mundane monotonous routine.

Having said this, here are "Turbo's ****Pilot Rules of Survival" (**** insert appropriate airframe MDS; e.g., gun pilot, scout, lift, assault, med, etc.). These rules may sound simple and elementary, but again in my experience, they've proven to be effective guidance.

1. Maintain or Regain Situational Awareness (SA). The primary duty of the pilot in command is the safe operation of the aircraft while performing the mission. Always maintain SA, or if lost, regaining SA becomes priority over all else. Rule #1 has application in all things aviation. This could be within your own cockpit (tasks or distractions) or beyond the canopy (hostile actions, DVE, traffic, obstacles, etc.). The moment an aviator or aircrew loses SA, it directly affects the safety or success of the mission. We see it constantly in training where a trainee will become distracted with an error or misstep in a task standard and allow this error to create a cumulative distraction, negatively affecting all subsequent actions. The community has experienced numerous accidents where, despite the ongoing emergency or task, loss of SA occurred and was the ultimate cause of the catastrophe, not the EP itself. Think about EPs preceded with the term "when conditions permit." How often have we seen disaster for lack of SA on this term alone? Prioritize, fly the aircraft, crew coordinate, understand the airspace and weather patterns at your location, and crosscheck instruments (altitude, airspeed, torque, TGT) and other crewmembers.

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2. Maintain or Regain Nr (rotor rpm). This should be a no-brainer, yet it is surprising how many can state the limit of an EP for rotor RPM maintenance, but fail to react correctly (if at all) with control inputs to maintain or recover Nr. To state it simply, the only thing on an Army rotary-wing aircraft that flies is the rotor system. Everything else (including the crew) is along for the ride and cannot produce adequate lift to overcome gravity. Aircrews or ****pilots who do not contribute adequate attention to maintaining or regaining Nr, which has fallen outside the limits adequate for producing total lift, exceeding gross weight or environmental conditions, will fall victim to gravity and potential ground impact.

3. Never Stop Flying the Aircraft. Throughout the course of aviation history are countless catastrophic examples where a crew essentially stopped flying the aircraft whether due to hopeless consideration in a crash sequence or failure to properly coordinate crew actions. "I've got it!" Got what? Oh, you mean you have the controls? See Rule #1. Think about the many crews that have crashed a totally airworthy aircraft following a missed instrument approach? Again, see Rule #1. Conversely, think of the times an aircraft and passengers have been saved because the crew never gave up. U.S. Airways Flight 1549 going into the Hudson River comes to mind. Despite the odds facing Captain Chesney B. "Sully" Sullenberger, he did not give up flying his aircraft all the way to the scene of the crash that, as you know, proved to be the singular most important step in the entire event. Never stop flying the aircraft, even on the ground, until all rotor and engine noises have ceased. And don't shut down any instruments or sensors until all rotors have stopped.

4. Don't do Stupid S _ _ t. This one can be summed up in one of two categories, either a disregard for known or published standards or policy or operating in a moment absent of critical consideration or judgment. If you, a crewmember, or element of your formation hints at willful violations of known standards, such as "showing off" (here's a photo opportunity, watch this, or watch me, etc.), then it could constitute being categorized as stupid s_ _ t. Do not fall victim to illusions of grandeur. No amount of experience can overcome the fatal or public humiliation of a failed experiment beyond the bounds of good judgment or skill. Best case, it reflects negatively on you and the unit; worse case, it could get someone killed or injured in addition to reflecting negatively on you and the unit. Unfortunately, there are vast examples to cite in violation of this rule. The best aviators and units I know are those who exhibit standards-based conduct as a means of impressing others, not those who attempt Hollywood moments. A former commander frequently summed it up adequately, "Do not inadvertently become the main effort." When in doubt, just **DON'T DO STUPID S _ _ T**.

5. Always Shoot Back. This particular rule isn't always exactly as it sounds. This, of course, applies primarily in a hostile environment. And while it could potentially be in contravention to weapons control status or rules of engagement, the point isn't to immediately shoot to kill or destroy. The initial purpose of including this rule is a means of putting the potential threat in a "time-out." In previous deployments, my aircraft or formation came under enemy fire on frequent occasions. Of these, the exact point of origin was often, if not impossible, to ascertain, particularly without immediate visual contact or audible alert from ground elements. So as a method of buying time to escape the engagement zone, consider making noise using organic weapons systems (the M240 machine gun, .50 cal, Mk 4 Folding-Fin Aerial Rocket or

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the 30mm chain gun). These have a similar effect on enemy forces, as does the sound of cocking a pump shotgun in a home invasion scenario. This alone sometimes is all you need to break contact and preserve combat power as the situation is developed or bypassed. The flash-bang report your organic weapons system conveys can be an impressive and effective complement to your aircraft survivability equipment. The enemy will not know whether you are directing fire at him, thus buying you the time to increase SA or distance from the shooter.

OK, so there you have it, Turbo's Five Gun Pilot (scout pilot, lift pilot, assault pilot, med pilot, CAC pilot, etc.) Rules of Survival. Over the years, I've edited slightly, adding or deleting depending on the audience or operating environment. Nevertheless, these five principles have remained. Breaking it all down, these rules ultimately support a positive balance in the aerodynamic capital account. Compromise of any could result in a mishap; adherence to all are critical to both mission accomplishment, aircrew safety and a sound unit of excellence.

TURBO'S 5 GUN PILOT RULES OF SURVIVAL

1. **Maintain or Regain Situational Awareness.**
2. **Maintain or Regain Rotor RPM.**
3. **NEVER Stop Flying the Aircraft.**
4. **Do Not Do Stupid S_ _T!**
5. **Always [Be Prepared to] Shoot Back.**

AMCOM Safety & Maintenance Messages

https://asmprd.redstone.army.mil/

Broken Wing Awards

The Army Aviation Broken Wing Award recognizes aircrew members who demonstrate a high degree of professional skill while recovering an aircraft from an in-flight failure or malfunction, requiring an emergency landing. Requirements for the award are in DA PAM 385-10, Para 6-3f.

CW2 Fransesco M. Foschetti
C Company, 1-10 ARB, TF Phoenix, Afghanistan

During final approach to Bagram Airfield, one of the AH-64D's tail rotor paddles broke at the root and separated from the aircraft. This imbalanced condition caused the tail rotor assembly to separate completely from the aircraft. Upon realization of the situation, CW2 Foschetti immediately took the controls to gain control of the aircraft. He manipulated the aircraft in an attempt to gain airspeed and minimize erratic yaw movements and an uncommanded descent. As he attempted to gain airspeed, he noticed a two-story building located in the vicinity of the intended landing zone. CW2 Foschetti determined the aircraft would be unable to gain sufficient airspeed to continue flight and elected to land short of the building. As his aircraft approached the ground, CW2 Foschetti put it into a nose high attitude to slow the aircraft. Prior to touchdown, the aircraft began to spin, CW2 Foschetti applied right cyclic, allowing the aircraft to set down in the most advantageous attitude. CW2 Foschetti's composure under pressure and superior airmanship prevented what could have been a catastrophic accident and loss of life.

CW2 Gabriel A. Torney
Task Force Brawler, Forward Operating Base Shank, Afghanistan

While flying on a mission in support of a QRF exfiltration, CW2 Torney's OH-58D was engaged by enemy fire. At the time, he was scanning the area with his M4 positioned out the cockpit door. He was struck by shrapnel from a round that passed through the chin bubble and center console. The shrapnel penetrated his forearm and face, blurring his vision. Additionally, a round passed through his right leg, dislocating his knee, and lodged in his left leg. Simultaneously, a round struck the pilot on the controls rendering him unconscious. The aircraft pitched up 90 degrees and began to roll over onto its side. CW2 Torney immediately recognized the extreme situation and assumed the flight controls. He was able to recover the aircraft from the maneuver, notify the flight lead, and fly the aircraft to a secure MEDEVAC LZ all while under duress and with limited vision. CW2 Torney's composure under pressure, response to an emergency situation, and superior airmanship prevented the loss of the aircraft.

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Class A – C Mishap Tables

	Manned Aircraft Class A – C Mishap Table									
		FY 11					FY 12			
	Month	Class A Mishaps	Class B Mishaps	Class C Mishaps	Army Fatalities		Class A Mishaps	Class B Mishaps	Class C Mishaps	Army Fatalities
1st Qtr	October	0	1	3			2	1	6	1
	November	0	2	14			1	1	5	0
	December	2	1	4	4		2	2	8	4
2nd Qtr	January	0	0	8			2	0	9	0
	February	0	2	2			2	1	5	0
	March	2	1	5			1	2	11	0
3rd Qtr	April	2	1	11						
	May	2	2	2	1					
	June	3	1	3	2					
4th Qtr	July	2	2	9	2					
	August	2	2	9	2					
	September	0	1	5	0					
	Total for Year	15	16	75	11	Year to Date	10	7	44	5

As of 5 Apr 12

UAS Class A – C Mishap Table									
	FY 11 UAS Mishaps					FY 12 UAS Mishaps			
	Class A Mishaps	Class B Mishaps	Class C Mishaps	Total		Class A Mishaps	Class B Mishaps	Class C Mishaps	Total
MQ-1	2		1	3	W/GE	1			1
MQ-5	3		1	4	Hunter	1	1	2	4
RQ-7	1	11	30	42	Shadow		5	9	14
RQ-11					Raven				
RQ-16A			3	3	T- Hawk				
MQ-18A									
SUAV			1	1	SUAV			4	4
Aerostat	6	9		15	Aerostat		1		1
Total Year	12	20	36	68	Year to Date	2	7	15	24

As of 5 Apr 12

Mishap Review: Medic Struck by MRB

During the conduct of a patient evacuation under NVGs, with the HH-60M holding a two-wheel pinnacle landing, the flight medic entered the main rotor disk area and was struck by the operating aircraft's main rotor blade. The Soldier suffered a fatal head injury.

History of flight

The accident aircraft was an HH-60M assigned to a MEDEVAC company in support of OEF. The crew's duty day began at 0700 hours when they reported to the TOC for mission/weather briefings. During the day, the aircraft repositioned from its home base to a forward operating base (FOB) in support of a combat operation being conducted. The aircraft returned to home base at 1500 hours. Shortly thereafter, the aircraft launched in support of a MEDEVAC request. The aircraft arrived at the FOB to await final clearance to proceed with the pickup. After nearly a 4-hour delay, the crew was given approval to proceed to an OP to pickup three urgent patients. They arrived at the designated LZ approximately 2000 hours.

During the approach and high/low recon, it was decided the terrain in the LZ would only support a two-wheel landing, with the LZ having a greater than 10 degree upslope. Winds were estimated off the nose at 19 knots, gusting to greater than 30 knots. After landing, the pilots maintained the aircraft in a level position with the main landing gear on the ground and forward cyclic applied. The forward cyclic, coupled with the greater than 10 degree slope of the LZ, put the tip cap of the rotor disk less than five feet from the ground. The shape of the LZ did not permit a left-side departure from the HH-60M because of excessive slope and multiple wire, picket, and boulder obstacles. On the right side of the aircraft, a narrow corridor lead to a HESCO wall in the vicinity of where the patients were collected and waiting evacuation. This channelizing terrain forced a very narrow path from the right side of the aircraft to the patient location. Additionally, exiting at the 3 o'clock position was inhibited by obstacles and rising terrain. The first time the flight medic exited and reentered the rotor disk, he used the 2 o'clock position and came back with two urgent patients. The flight medic then exited the aircraft to retrieve the third patient at the 2 o'clock position, but upon return, reentered the rotor disk area at the 12 to 1 o'clock position. The blade clearance to the front of the aircraft was 4 to 5 feet when it made contact with the flight medic's Army Combat Helmet (ACH), resulting in fatal injuries.

The accident board determined the aircrew failed to maintain positive two-way communication with the flight medic as he exited and reentered the rotor disk. The flight medic did not receive clearance from the cockpit before entering the rotor disk area. As a result, the crew could not verify that the flight medic knew the rotor disk was extremely low at the front of the aircraft. The inability to conduct positive two-way communication between the flight medic and the pilots prevented appropriate mitigation procedures to be implemented to avoid the low rotor blades. The board recommended that units develop a standardized system that requires flight medics to gain positive two-way communication and approval from the PC prior to entrance into the rotor disk area.

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Power to Prevent Mishaps (reprinted from 4Nov81 Flightfax)

In the compass, magnetic force serves to guide us: in the telephone, radio, and television set, to communicate; in ignition coils and magnetos, to spark our gasoline engines; in generators, to light our cities; in electric motors, to operate our appliances. The list goes on and on. Yet, despite daily reliance on this invisible force, we are seldom conscious of its existence. There is also a type of magnetism that can prevent aircraft mishaps. It is different from that produced by the flow of electric current. Nevertheless, it is magnetism just the same. It is personal influence.

While the force exerted by personal influence cannot be measured in units of newtons or dynes, the results it produces serve as positive proof of its existence. And don't underestimate its power. It is one of the most effective safety tools available. Unfortunately, misused, it can cause mishaps just as readily as it can prevent them.

Each person radiates this magnetic power during all his waking hours. It can't be turned off. So it is applied in a positive manner to improve safety or in a negative way to thwart it. Personal magnetism is transmitted in different ways: by example and instruction; by a positive or negative attitude; by request or directive coupled with some form of supervision; and even by complete indifference to a given situation. Often physical presence is sufficient to exert a powerful influence on others. Have you ever been part of a group telling shady stories when a minister unexpectedly walked in? What happened to those shady stories? Personal influence, in one form or another, is an ever-present force that can be used constructively or destructively. Its proper application is essential to safety in Army aviation.

Some years ago, the commander of one aviation unit insinuated it would "look good" if down time for scheduled PE inspections could be reduced. Obligingly, maintenance supervisors adopted a policy of returning aircraft to the flight line as soon as PE inspections were completed and signed off – even though long lists of discrepancies uncovered had not yet been cleared. These were left for flight line mechanics to correct. On paper, down time for scheduled inspections was substantially reduced. However, the end result was an increase in aircraft rejections by pilots as well as a rise in number of both in-flight problems and precautionary landings.

A somewhat similar situation arose when the commander of another aviation unit demanded a higher overall aircraft availability rate. The mechanics obliged him by taking every available shortcut they could devise. When excessive magneto drop could be corrected by opening the points, no further effort was made to determine and eliminate the true cause of the problem. If a landing gear oleo strut was low, it was inflated to the proper extension without ensuring the piston seals were serviceable and hydraulic fluid had not been lost. Likewise, mechanics use torque wrenches if they were handy; otherwise, they relied on the sense of 'feel" – except when the item being torqued happened to be a critical one. This kind of hurry-up maintenance increased aircraft availability for only a short time. As could have been predicted, the end result was an increase in number of pilot write-ups, aborted missions, and unscheduled maintenance.

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Yet, these aren't isolated instances. Each year there are problems of a similar nature. How many emergencies and mishaps have occurred because a mechanic failed to install a cotter pin? A connection was improperly tightened? A hydraulic line was inadequately secured? An inspector was lax? An MWO was not complied with? Bad habits are not taught in the classroom. Students aren't shown how to force a part in place; they aren't allowed to service an aircraft until it is properly grounded; nor are mechanics encouraged to perform maintenance without referring to appropriate technical manuals.

And the mechanic is not to be singled out. Pilots and other aviation personnel are equally vulnerable to temptations that drastically affect safety. More than 20 years ago, one student pilot decided to put on a "special" show for his girlfriend's benefit. After performing a series of aerobatic maneuvers over her house, he came in low, rolled his aircraft inverted – and promptly nosed into the ground. Some years later, another pilot decided to put on a one-man performance for his family who were spending the day at the beach. During a sharp pull-up and tight turn following a near-ground level pass, the aircraft stalled out and crashed before the eyes of the pilot's horrified wife and children.

During the same time period, another pilot lifted off in IMC on a VFR flight plan. Severe turbulence, thunderstorms and possible tornadoes were forecast. He crashed shortly after takeoff.

Before each of these missions, others knew of the pilot's intent. Yet, no one made any effort to prevent any of these flights or even advise against them. Could this silence have been interpreted as consent? One thing is certain: Analysis of these and other mishaps clearly establishes the human element as the predominant mishap cause factor.

Granted, a fuel pump shaft can shear and cause fuel starvation. This has happened. But what about the mechanic who plugs a disconnect fuel line with a candy wrapper, and then forgets to remove it when he reconnects the line? When the engine is started, fuel pressure partially dislodges the plug, permitting full flow. Then at some point during flight, the wrapper blocks the line, causing engine failure and a mishap. This also has happened.

Failure of pilots to perform proper preflight inspections has caused numerous mishaps – some fatal. So has failure to either positively secure or remove all loose items in helicopter scheduled to be flown with doors off.

And what about such common hazards as wires? Flying low level when it is not required by the mission, failure to perform ground or air reconnaissance before landing at unfamiliar sites, and failure to mark wire locations are just a few causes of wire strike mishaps. In one case, an aircraft on a low-level training mission struck wires and crashed. The pilot did not have a hazards map in his possession; had not received a thorough mission briefing; and was unsure as the exact location of his landing zone, the altitude at which he would be flying, or the precise route he would follow. Any wonder the aircraft struck wires?

Where do such unsafe practices come from? Since bad habits are not taught, how do they develop? Is it left up to each individual to figure out how to violate regulations; disregard TMs, checklists, and procedures; and take unnecessary risks? Or does he get help from others? In far too many instances, human error can be traced to direct or indirect personal command influence.

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A simple "they're rated" paired two inexperienced pilots for an administrative flight. The price? One aircraft. The same type of result was attained by a "He's-instrument-rated-so-put-him-on." An "I-can-catch-up-on-my-sleep-later" attitude cost a pilot his life.

The veteran pilot who likes to display his ability to perform low-level maneuvers, disregard checklists and procedures, violate regulations, and take unnecessary risks is going to entice some new pilot to do likewise. Where the veteran pilot may get by on skill, the novice most probably will not. Eventually, the veteran will likely fall victim to a situation he helped create.

A few years ago, a training plane from a military installation made headlines when it smashed into the side of a bridge while supposedly in the landing pattern. Could the subsequent discovery that other pilots frequently tested their skill by flying under the bridge have had any bearing on this mishap?

Can flying be 100 percent safe under all situations? Not any more than crossing the street or driving to work. In a combat environment, risk becomes an integral part of every mission. Marginal weather cannot be allowed to stop a flight necessary to evacuate wounded, or to supply reinforcements and equipment to soldiers cut off from their unit by the enemy.

Valor, coupled with training, experience, and ingenuity, is a major factor in winning battles and saving lives. But valor should never replace common sense. We must always bear in mind that the new aviator, particularly the younger person, is endowed with an overabundance of vitality, curiosity, and an adventurous spirit. There is nothing he can't do - particularly if he is encouraged to do it, has seen it done, or is left to his design while he gains experience.

Influence should begin at the top. The commander who is conscientious follows prescribed procedures, abides by regulations, and exercises sound judgment sets, by example, the course for his subordinates to follow. If he is lax; if he is guilty of breaking or bending regulations; if he does not select pilots to meet mission requirements; if he does not concern himself with conditions around his airfield; if he does not insist on each individual doing his job efficiently and in a professional manner, then he has lost his sense of direction. In time, those following him will lead others down the same path.

By actions and words, by refusal to lend the stamp of approval to improper methods or procedures, by the example set, commanders have the power to prevent mishaps through personal influence.

If you have comments, input, or contributions to Flightfax, feel free to contact the Aviation Directorate, U.S. Army Combat Readiness/Safety Center at com (334) 255-3530; DSN 558

Selected Aircraft Mishap Briefs

Information based on Preliminary reports of aircraft mishaps reported in March 2012.

<u>Utility helicopters</u>

UH-60 

-L series. Aircraft was in hot refuel when a clip from the grounding cable separated and contacted a main rotor blade. (Class C)

-L Series. Failure of the No. 1 input module occurred during a high-speed shaft balance check. (Class C)

-L Series. During landing at a training site, a VS-17 landing marker was ingested into the main rotor system, resulting in damage to two blades. (Class C)

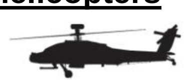
-L Series. Post-flight inspection revealed damage to all four main rotor blades due to contact with the BFT antenna during night training. Damage is suspected to have occurred during a roll-on landing. (Class C)

-L Series. Crewmember sustained lacerations to one finger during M134 firing when he flight glove caught his flight glove in the feeder de-linker. (Class C)

-A Series. Damage to the undercarriage occurred when the aircraft landed on rocks in snow-covered terrain during NVG training. (Class C)

-A Series. During NVG transport mission two UH-60s meshed main rotor blades while ground taxiing, following pax drop-off. (Class C)

<u>Attack helicopters</u>

AH-64D 

-Aircraft contacted and severed a PGSS aerostat tether as crew was flying security over the COP under FLIR. Sister ship observed the strike although the aircraft crew detected nothing. Damage to the No. 2 MRB tip cap found on post-flight confirmed contact. (Class B)

-Crew was at a 25- to 40-foot hover when they experienced loss of lift during a pedal turn. Aircraft impacted the ground and the main rotor system contacted the canopy, injuring the front-seat pilot. Aircraft was destroyed. (Class A)

-No. 1 engine cowling opened in flight on MTF. (Class C)

-L2 panel separated in flight. (Class C)

<u>Observation helicopters</u>

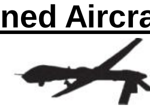
OH-58 

-D series. Aircraft experienced an NP exceedance (124%/8 sec) while in FADEC manual mode at 100% RPM during engine run-up.   (Class C)

-C series. Aircraft main rotor system made contact with the ground during primary contact phase training. Main rotor system and transmission separated in the crash sequence. IP and student pilot sustained minor injuries. (Class B)

-A series. Aircraft experienced an N2 spike (113%) during a demonstrated autorotation at 200 feet AGL. (Class C)

<u>Unmanned Aircraft Systems</u>

MQ-1 

-System exhibited low oil temp and pressure indications accompanied by manifold temperature spikes. Crew lost link as system was returning to base. (Class A)

U.S. ARMY COMBAT READINESS/SAFETY CENTER

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