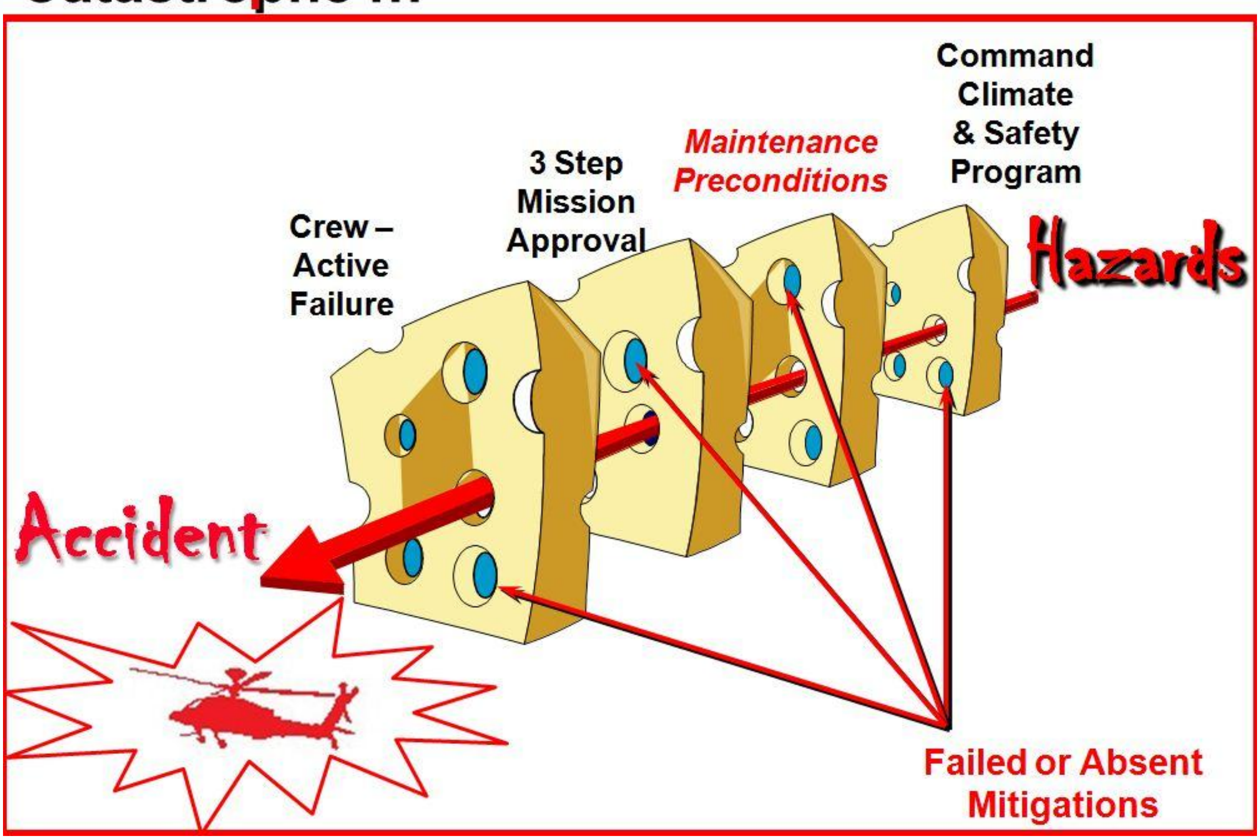
Number 13 **May 2012**

Flightfax®

Online Report of Army Aircraft Mishaps

The online version of Flightfax is one year old this month. Yet, we have little to celebrate. Year to date for fiscal year 2012, we have had 12 Class A accidents and 9 fatalities. For the same time period in 2011, we had 6 Class A's with 4 fatalities. Clearly, as an enterprise, we are missing opportunities in preventing accidents. In the previous three months of Flightfax, we've thoroughly outlined Command Climate & Safety Program, 3-Step Mission Approval, and Crew failures. This month, we highlight Maintenance.

Don't Miss an Opportunity to Prevent Catastrophe ...



The figure above illustrates a model of human error and how it contributes to the breakdown of safe flight operations (reference Reason, 2000; Human Error: Models and Management, Swiss Cheese Model of System Accidents as found at http://www.ncbi.nlm.nih.gov/pmc/articles/pmc1117770/). In the "Swiss Cheese Model," failures can be either active or latent.

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An active failure is an unsafe act that presents an immediate adverse effect. These acts are usually made by aircrew members or maintainers. An example includes a pilot raising the collective instead of lowering it during a compressor stall. Another example is using wrong-sized bolts on a windscreen replacement. Active failures represent deviations from effective mitigations, and are the "holes" in the system that allow hazards to pass and become accidents.

Similar to safe behavior and practices, unsafe acts and practices are also set up by preconditions within the aviation unit. Preconditions for unsafe acts may be such things as a loss of situational awareness by the pilot, poor crew coordination, or poor maintenance on the aircraft. These preconditions, however, are singularly established by poor supervisory practices; for example, inadequate training, poor crew selection, or improper maintenance management.

We all know that Aviation is a team effort. Let's not forget that everyone on the team is a starter for each and every mission. There are no second-string teammates! Our maintainers – both on the flight line and hard at work in the back shops – are as important as the pilots sitting in the cockpit. Often enough, the operational mission and environment in which our aircrews operate present plenty of hazards which challenge their skills. In an effort to assist you in improving your maintenance "special teams," we've included two articles from previous editions of Flightfax. The first outlines human factors in aviation maintenance from November 2003. The second, our Blast from the Past article from 1991, highlights good maintenance can make a difference, and "an Army pilot is not better than the aircraft he is flying, and the aircraft is no better than the person who services it."

Aviation maintenance is not just a mission – well conducted and managed, it is an integral part of accident prevention. Don't miss an opportunity to prevent an accident, because second best could mean *dead last*.

Until next month, fly safe!
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https://safety.army.mil/atf/

Human Factors in Aviation Maintenance reprinted from November 2003 Flightfax

Human error is cited as a major cause of aviation mishaps. When it comes to human error, the blame has traditionally been laid on flight crews rather than on maintainers. Although human factors-related maintenance failures are not always evident, the National Transportation Safety Board (NTSB) and the U.S. Army Safety Center (USASC) routinely investigate maintainers' performance.

The human factors that can affect aviation maintenance include: (1) environmental factors; (2) individual human factors; and (3) human-factors training for maintenance personnel. Let's look at these in detail.

Environmental human factors

The aviation mechanic works in a variety of environments. Maintainers work on aircraft not only in hangars, but also on flight lines in all types of weather at any time of the day or night. In the case of military aviation, mechanics may even have to work in a chemical environment which could drastically affect their performance. Categorized more broadly, these environmental factors can be broken into noise and weather conditions.

- Noise. The noise an aviation mechanic may encounter varies considerably, but is universally loud. It's not unusual for the noise on the airport ramp or apron area to exceed 85dB, loud enough to cause hearing damage if exposure is prolonged. Turbine engine, rotor blade, and transmission noise can contribute to distraction, stress, and fatigue. If not closely supervised, a distracted mechanic could be killed or injured, or could severely damage an aircraft.

- Weather conditions. Environmental temperatures vary depending on the time of year, region of the world, and whether the workplace is climate controlled. The physical effects of working in conditions that are too hot or too cold can substantially decrease a mechanic's performance.

When working in extreme temperatures, a mechanic may rush through the task and overlook an important step. Supervisors should do everything possible to provide adequate shelter from inclement weather so that mechanics can work effectively. If this is impossible, mechanics should take breaks to either warm up or cool down. Hangars with climate control are the ideal working environment as long as the doors remain closed.

Individual human factors

The leader or supervisor must be able to differentiate between errors and violations when considering a mechanic's performance. Individual factors such as physical fitness, fatigue, and stressors must be taken into account when considering what might lead a person to make errors or violations. The leader or supervisor should consider these factors seriously before assigning a mechanic to work on a multi-million dollar aircraft.

- Physical fitness. A physically fit mechanic has more energy and tends to be more productive than a deconditioned mechanic who may not be able to do what is required for a particular task. Fitness and health can have a significant effect upon a mechanic's physical and cognitive job performance.

Several conditions can affect health and fitness, and diminish a mechanic's ability to perform proper maintenance. These include physical illnesses, mental illnesses, and injuries and can range from a winter cold or flu to a sprained or broken ankle.

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- Fatigue. Another factor affecting maintenance errors is fatigue. One cannot overemphasize the importance of getting a good night's sleep to do a good job the next day. Unlike their civilian counterparts, military aviation mechanics have many other duties in addition to the task of maintaining an aircraft. It's not unusual for a military mechanic to work a 10- to 12-hour workday. Habitually long work days can cause confusion and fatigue, increasing the chance of human error. To prevent fatigue-related accidents, leaders and supervisors must understand how fatigue and the body's sleep and wake cycles affect each other.

- Stress. Everyone experiences stress in one form or another. Aviation mechanics are stressed by the demands place upon them. Problems develop when mechanics are unable to control their reactions to job demands. This is why it's important for supervisors to recognize the symptoms of stress in their employees. Money problems, marriage conflicts, a new baby, or death of a family member can all increase stress and worsen the problem. Although it is impossible to eliminate human error, learning to effectively manage stress can reduce human errors.

Some ways to manage stress include relaxation techniques, counseling, a good sleep and a healthy diet. Making resources available and encouraging mechanics within your organization to learn to cope with stress can decrease human error.

Human factors training

Effective organizations realize that leaders need to understand human factors training so they can recognize the role that good or bad planning has on the performance of maintenance. The vitality of a human factors program depends upon proper planning in hiring qualified, alert individuals, and maintaining tools, equipment, materiel, maintenance data, and facilities. This can be achieved by incorporating organizational safety, qualified trainers, and error management into the human factors training program.

- Organizational safety. Human factors play a huge role in the quality of maintenance training. Statistics show that 18 percent of all accidents are due to maintenance factors. To reduce errors and make aviation maintenance more reliable, human factors training and research must be an ongoing effort. The following are steps organizations can take to do this:

- Provide and share knowledge with maintenance personnel.
- Develop skills.
- Positively influence attitude.
- Positively influence behavior.
- Practice daily what is taught and learned.

- Trainer. An effectively human factors training program begins with a good trainer thoroughly knowing the subject. Some guidelines to look for when choosing a trainer are formal education on the subject, training to teach the subject, and at least 3 years experience with a maintenance organization. The trainer must be able to motivate people, not just pass on knowledge.

The training program should include initial and sustainment training to keep employees current in human factors, target areas where training is needed, and evaluate the training program's effectiveness. The best training is tailored to each organization and presented by an

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instructor from within the organization. This way the trainer will know the areas within the organization needing the most focus.

- Error management. This concept focuses on eliminating errors and can be broken down further into error management and error containment. By monitoring and documenting incidents and accidents, organizations can compile information helpful in predicting and preventing these errors in the future.

On June 10, 1990, the left windscreen on a British Airways Flight 5390 blew out shortly after takeoff. Although the pilot was sucked halfway out the hole, other crewmembers held onto him until the co-pilot could land the airplane. In this incident, the windscreen had been replaced using the wrong size bolts. The shift maintenance manager was so short staffed that he replaced the windshield himself. He used the bolts that held the old screen in place for comparison as he looked for new bolts the same size. He ended up using bolts that were longer and thinner than the ones he needed. He also failed to notice that the countersink was too low. He signed off the job himself without any type of pressure check or duplicate check. Eighty-four of the ninety bolts holding the new windscreen were too small.

The employees in this incident were considered qualified, competent, and reliable. This situation could have been avoided had the employees practiced error management. With today's technology, there is little room for error and human-factors training is vital to reducing the aviation accident/incident rate.

--The author, Scott E. Cornelius, 1SG U.S. Army retired, wrote this article while attending Embry-Riddle Aeronautical University, Fort Rucker, AL. It appeared in the November 2003 issue of Flightfax.

"In flying I have learned that carelessness and overconfidence are usually far more dangerous than deliberately accepted risks."

- Wilbur Wright, September 1900

Class A – C Mishap Tables

Manned Aircraft Class A – C Mishap Table										
	Month	FY 11					FY 12			
		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	2	6	1
	November	0	2	14			1	1	9	0
	December	2	1	4	4		2	2	5	4
2nd Qtr	January	0	0	8			2	0	9	0
	February	0	2	2			2	1	6	0
	March	2	1	5			1	2	10	0
3rd Qtr	April	2	1	11			2	1	5	4
	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	12	9	50	9

As of 11 May 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		6	9	15
RQ-11					Raven				
RQ-16A			3	3	T- Hawk				
MQ-18A									
SUAV			1	1	SUAV			4	4
Aerostat	6	9		15	Aerostat		3		3
Total Year	12	20	36	68	Year to Date	2	10	15	27

As of 11 May 12

Mishap Review: AH-64D Loss of TR Thrust

While responding to support troops in contact, the AH-64D crew experienced a loss of tail rotor thrust when the aft hanger bearing coupler sheared at the #5 tail rotor shaft. The crew was forced to land to an unimproved field. After touchdown, the aircraft rolled onto its left side.

History of flight

The accident aircraft was an AH-64D assigned to an Aerial Weapons Team (AWT) with a mission of on-call support to troops-in-contact (TIC) or other support as tasked by brigade. The crew's show time was 1400 hours, followed by mission and crew briefs and aircraft preflight and run-up. The AWT launched at 1600 hours to conduct a recon mission that lasted 1.6 hours. During the flight, the crew noticed an unusual intermittent vibration suspected by the crew to be associated with the 30mm. Upon return, the PC discussed the vibration with maintenance personnel. Maintenance indicated that any repairs would occur upon conclusion of the day's mission due to minimal manning on the night shift.

At 2000 hours, the AWT launched in support of a TIC. En route to the FARP, the accident aircraft had a Gearbox Vibration caution message. The crew decided to shut down at the FARP to troubleshoot the problem. The PC was instructed to conduct a ground run after seeking assistance from the TOC and production control. During the ground run, the caution message did not illuminate. A request for a one-time flight back to home base was approved by the battle captain and the aircraft departed at approximately 2300 hours. One minute after departure from the FARP, the intermittent Gearbox Vibration caution message again illuminated. The assumption was made that this was due to a faulty sensor and the aircraft continued its one-time flight to home base. Approximately 25 minutes into the flight, the intermittent vibration became constant, a loud pop was heard with a 25-degree right yaw and no response to pedal input. The pilot on the controls, flying with the Pilot Night Vision System (PNVS) in the back seat, attempted to arrest the yaw by increasing airspeed to 132 knots and adjusting the cyclic and collective. The crew was unable to arrest the yaw and elected to land with minimal forward airspeed (due to unknown landing conditions) to an open field, controlling the yaw with reduction of the power control levers. The reduction of

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power, combined with the increase in collective to cushion the landing, caused the rotor to droop enough to kick the main generators offline and remove power from the PNVS. With no PNVS, the crew leveled the aircraft and impacted the ground with all three landing gears, in a right yaw and no ground speed. The right sideslip angle and yaw rate caused the aircraft to roll on its left side. The aircraft received substantial damage. The crew received no injuries.

Crewmember experience

The PC, sitting in the front seat, had more than 4000 hours total flight time, with 1700 in the AH-64D (1300 as a PC) and 750 NVD hours and 1300 hours combat time. The PI, flying in the back seat, had 525 hours total time, 440 AH-64D hours with 130 NVS hours and 248 hours combat.

Commentary

The accident board determined that the #5 tail rotor driveshaft vibrated and caused the aft hanger bearing coupling to shear due to improper maintenance. One week prior to the incident, the intermediate gearbox and #5 tail rotor drive shaft were removed to complete other maintenance tasks. During reinstallation of the drive shaft, the hanger bearing bolts were installed without appropriate torque. The repair occurred over a two day period, requiring two maintenance hand-offs between the day and night shifts. The day shift installed the hanger bolts, but left the torque requirements to the night shift. The task was signed off and TI'ed with inadequate torque applied. Prior to the accident day, the aircraft had completed a dynamic drive MOC as well as a short flight that was aborted due to poor weather. The aircraft was equipped with a modernized signal processing unit (MSPU), which recorded a caution for vibration in the aft hanger bearing and driveshaft area during the MOC and each subsequent flight. The MSPU data was only required to be downloaded every 14 days or 25 flight hours. The board recommended that MSPU data be reviewed following dynamic drive MOCs. Additionally, the board determined the battle captain failed to follow proper procedures in approving the one-time maintenance recovery flight without notifying the commander, and the aircrew failed to diagnose and properly respond to an emergency condition when the gearbox vibration caution message illuminated (land as soon as possible).

Mishap Review: AH-64D Test Flight

During the conduct of a MTF, at an altitude of 200 feet AGL and airspeed below ETL, the aircraft developed a high rate of descent until ground impact. The crash resulted in serious injuries to one crewmember and substantial damage to the aircraft.

History of flight

The accident aircraft was an AH-64D requiring an in-flight operational test of the Common Missile Warning System (CMWS). The crew's show time was 0600 hours. At approximately 1015 hours the flight was approved by the task force commander. Weather was VFR with winds out of the northeast at 17 knots.

At 1145 the crew cranked, completed run-up checks to include an MOC on the APU power take-off clutch, and repositioned to complete a HIT check. Following the HIT check the accident aircraft was cleared to perform a high hover in center sod to conduct the CMWS operational check. The crew initiated a climb to a high hover with forward airspeed into a 18-20 knot headwind. During the initial phase of the flight the operational check failed. The pilot on the controls then executed a slow right pedal and cyclic turn to return to parking. As the aircraft entered a downwind condition, an undetected and uncommanded descent of approximated 200 feet per minute occurred. Half-way through the turn the aircraft had descended to 100 feet AGL. The pilot on the controls recognized the descent and increased power but the aircraft continued to descend at an increased descent rate of 400 feet per minute. In a full downwind condition, the aircraft decelerated through ETL with insufficient power to arrest the rate of descent. At 50 feet AGL, the descent had increased to 850 feet per minute. Just prior to impact the aircraft was nearing a descent rate of 3000 feet per minute.

The aircraft contacted the ground in a 10 degrees nose low attitude and 20 knots forward groundspeed resulting in significant damage. Additionally, the main rotor contacted the forward crew station resulting in serious injuries to the pilot.

Crewmember experience

The PC/MTP, sitting in the back seat, had more than 1400 hours total flight time, with 1300 in the AH-64D (750 as a PC) and 700 hours combat time. The PI, flying in the front seat, had 1700 hours total time, 1500 hours in the AH-64D (680 PC) and 780 hours combat time. He was also a qualified maintenance test pilot.

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Commentary

The accident board determined the crew failed to identify the initial rate of descent developed during the downwind pedal turn. This, and the slow application of available aircraft power, resulted in the aircraft developing a high rate of descent from which the crew was unable to recover.

All information contained in this report is for accident prevention use only. Do no disseminate outside DOD without prior approval from the USACRC.
Access the full preliminary report on the CRC RMIS under Accident Overview Preliminary Accident Report
https://rmis.army.mil/rmis/asmis.main1 AKO Password and RMIS Permission required

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ARMY PRELIMINARY LOSS REPORT 12077

UH-60L CRASH CLAIMS FOUR SOLDIERS' LIVES

Four 25th Combat Aviation Brigade, USFOR-A, Soldiers were killed in a UH-60L Blackhawk crash that occurred on 19 April 2011, at approximately 2130 local in Afghanistan. The two CW2 pilots and two crew members, both Specialists, were on board the aircraft when it crashed. No one survived the crash and the aircraft was a total loss. A Centralized Accident Investigation (CAI) team from the US Army Combat Readiness/Safety Center is investigating.

This is the 9th Class A **Flight** fatality in FY12 compared to **4** for the same time frame in FY11. This PLR does not identify specific root causes of this incident as the investigation is ongoing. Further details will be available at a later date on RMIS (RMIS Login Required).

Preliminary Loss Reports (PLR) are ***For Official Use Only*** and are to provide leaders with awareness of Army loss as we experience it and to point out potential trends that affect our combat readiness.

Our Army depends on you to use these PLRs to help Soldiers understand the impact of decisions made on and off duty.

The U.S. ARMY COMBAT READINESS/SAFETY CENTER is interested in your comments; please click here to provide feedback on the Preliminary Loss Reports (PLR). FAQs and additional resources can be found on the USACR/Safety Center website at https://safety.army.mil

Good Maintenance Can Make the Difference. 2 Jan 91 Flightfax

An Army pilot is no better than the aircraft he is flying, and the aircraft is no better than the person who services it.

There are only two real causes of maintenance induced accidents: Someone either didn't do the job or didn't do the job correctly. With possibly a few exceptions, maintenance errors are preventable and inexcusable. There is no reason why they cannot be virtually eliminated. Good maintenance is trained personnel following correct procedures *all the time*. When authorized procedures are not followed, the stage is set for accidents.

It's easy to blame the pilots. It's easy to see why crew error gets a lot of attention because, statistically, human error by pilots is the largest single cause of aviation accidents. But even where a pilot makes a mistake that leads to an accident, we sometimes find maintenance was also a factor. For example, in the following case, an IP failed to follow the proper emergency procedures when he lost power on the No. 1 engine of a UH-60. As a result, rotor rpm immediately began to decay and continued downward to the point that further flight was impossible, and the aircraft crashed.

The IP had continued to operate the aircraft as the fuel decreased below a restriction imposed by a logbook entry. Specifically, the entry restricted flight when indicated fuel on the No. 1 system was below 400 pounds. As a result, he placed the aircraft in a condition where fuel starvation on No. 1 engine could happen.

When the low fuel pressure light came on during approach for landing, the IP failed to immediately place the engine fuel system selector switch to cross-feed as specified in the operator's manual. And, apprehensive that he might lose the remaining engine too, the IP failed to properly divide his attention between aircraft control and monitoring flight instruments that would have told him he was losing rotor rpm.

This appears to be a clear-cut case of pilot error, but there's more to the story than that. True, the No. 1 engine failed because of fuel starvation, but the output line for the No. 1 engine submerged fuel boost pump was not connected. This allowed air to enter the fuel system when the free line was exposed to air in the fuel cell.

At an undetermined time, and for an undetermined reason, the line had been disconnected. When the fault was first documented, unit maintenance personnel did not take adequate steps to troubleshoot the problem and take corrective action.

Sometimes it's just plain carelessness. Too many times, the maintenance error that causes an accident is as simple as leaving something where it doesn't belong, and sooner or later it finds its way into an area where it does mischief. The variety of these objects seems endless: bolts, washers, tools, shop towels, even soda cans have been found under drive shafts, jamming flight controls, blocking air ducts, and on and on. In the case of a UH-1 Class C, it was a DD Form 1577-2 condition tag that was discovered in the engine inlet area behind the 6 o'clock strut and against the variable inlet guide vanes. The aircraft had been equipped with an improved particle separator, and the tag must have been left inside the particle separator

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during previous maintenance.

This aircrew was luckier than some. They were hovering over an airfield, after returning from a training flight, when the aircraft's engine experienced a catastrophic compressor stall. The aircraft lost power, yawed, and settled. The pilot initiated engine failure procedures and landed without further damage to the aircraft.

Just because it's on the aircraft doesn't mean it's right. The fact that something is installed on an aircraft doesn't always mean that it is the right part or that it is installed correctly. Following is an example of what can happen as a result.

While performing maintenance test flight at about 10,000 feet AGL, the crew of a UH-1 heard a report from the rear of the aircraft. There were no abnormal instrument indications and control responses were normal. The pilot performed emergency procedures, landed, and shut down the aircraft. After checking for damage, the crew chief informed the pilot that the oil cooler fan turbine had disintegrated, and there was extensive sheet metal damage to the fan compartment.

The oil cooler fan had failed due to an overspeed caused by installation of an improper reducer fitting that increased the fan-driven airflow beyond design limits. The oil cooler fan and shroud assembly were installed and inspected 134 hours previously, but the installation inspection was not performed in accordance with the technical manual, which clearly states the orifice diameter cannot be larger than .255-inch. The installed fitting orifice had a diameter of .680-inch.

What it takes to have good maintenance.

- Awareness on the part of supervisors about the training, experience, and abilities of every person under their supervision.

- Qualified technical inspectors.

- Up-to-date technical manuals available in each unit in sufficient quantities to be in the hands of mechanics. It's true that after a mechanic works on an aircraft for a while, he remembers torques and even assembly procedures, but manuals change. Mechanics *must* use the book every time.

- Scheduling of flights to ensure preventive maintenance inspections are performed when due.

- Submission of DA Form 2028 or DA Form 2028-2 when required. Errors may appear in publications from time to time or some important item may be omitted. The quicker errors are known, the quicker they will be corrected.

- Constant command emphasis on all the above points.

We're all in this together. In the best aviation units, there is no attitude of "us and them" among people who fly aircraft and those who maintain them. There is instead an atmosphere of mutual respect that breeds confidence and trust between crews. In this kind of unit, when an aircraft leaves the ground, the aircrew knows that it is mission capable, and the maintenance crew knows they have done their part to ensure the mission is accomplished.

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Mechanic's Code

As a maintenance technician, I recognize my obligations –

To the United States Army, which trusts that I am technically qualified for the tasks expected of me.

To the aircrews and passengers, who trust their lives and safety to my mechanical skills.

To my organization, which expects me to be a professional mechanic as well as a professional soldier.

To my fellow mechanics, who as team members must depend upon me for a task completed.

To myself, for the personal satisfaction of a professional job well done.

To discharge these responsibilities –

I will perform maintenance of the highest quality to assure the safety of every flight.

I will always be sure of my work or, when in doubt, consult my supervisor.

I will strive to improve my professional skill by attention to duty and self-education.

I will not allow personal desires or considerations to affect my performance of duty.

I will never attempt to perform duty when my mental or physical condition might lead to maintenance error.

I will keep my tools and equipment in first-class condition to ensure a job worthy of the professional mechanic that I am.

I pledge adherence to these principles to reflect credit to myself, my fellow workers, and my profession.

Selected Aircraft Mishap Briefs

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

Utility helicopters

UH-60

-L series. Aircraft crashed during the conduct of a MEDEVAC mission. Four fatalities. (Class A)

-M Series. Main rotor contacted a tree during the approach to an LZ. One main rotor blade replaced. (Class C)

Mi-8

-Rotor RPM drooped on climb-out. Aircraft landed hard sustaining damage. (Class B)

Observation helicopters

MH-6M

-Aircraft touched down hard during multi-ship landing. Post-flight inspection revealed damage to the FLIR and fuselage. (Class C)

Cargo helicopters

CH-47

-D series. Forward rotor system contacted terrain during an NVG upslope landing. (Class A)

-F Series. Aircraft experienced a No. 2 engine overtemp/torque during sling-load landing. Engine replacement required. (Class C)

MH-47G

-Crew experienced a rotor system over-speed indication during descent. Post-flight inspection confirmed condition. (Class C)

Unmanned Aircraft Systems

RQ-7B

-Ground Control Station lost link with the system during return flight. UA subsequently descended and crashed into a mountainside. (Class B)

A160

-Vehicle landed hard after failure of the transmission. UA and mission package damaged. (Class A)

Aerostat

-While being lowered due to approaching weather, the aerostat was thrust downward to ground impact by a reported 87 MPH wind gust. (Class B)

-Aerostat tether broke while aloft at 1500 feet as a result of a wind gust that exceeded forecast winds aloft. Aerostat was not located/recovered after drifting away. (Class B)

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

U.S. ARMY COMBAT READINESS/SAFETY CENTER

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