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Flightfax®

Online Report of Army Aircraft Mishaps

"Any job done professionally is inherently safe."

-Edward E. Waldron II

In this edition we provide the FY12 preliminary report of Aviation mishaps. The good news is that Aviation fatalities for FY12 were at a decade low, improving on last year's fatality rate with a drop from 11 deaths to 10. The positive trend continues when considering total Class A-C mishaps; the total 118 Class A-C mishaps in FY12 is a decrease from 123 in the previous year.

Last year, we reported for FY11 an increase in Class C with the corresponding drop in Class A and B mishaps. This may be a strong indicator of healthy learning organizations applying lessons learned from lesser incidents. With an FY12 increase to 21 Class A accidents from the 15 in FY11, we may be learning much harder lessons.

The causes of FY12 accidents will be no surprise for anyone who has been reading Flightfax throughout FY12. Human error was the cause factor in 83% of the Class A and B mishaps.

"Analysis of mishaps in the last fiscal year showed that the causes were neither new nor unique. Commanders and aviators just found new ways to repeat the same old mistakes and caused so-called 'new' mishaps. In almost every case, the errors causing the mishaps were the results of the people involved, failing to do their jobs by the book." This quote, from this month's Blast From the Past, absolutely applies to FY12's stats – yet were delivered in the aircraft accident report for FY81. It is now thirty-one years later, and even the analysis and summary are nothing new. The best way to prevent human error mishaps is active intervention by observers. Accidents don't occur in a vacuum – someone knows when Aviation Soldiers are engaging in high-risk behavior. If it is not a leader, it is a fellow Soldier or buddy. Fate isn't responsible when a Soldier dies in an accident; we're the ones responsible if we didn't do everything we could to prevent it from happening.

As this edition of Flightfax enters us into another fiscal year of Aviation mishap reporting, last year's stats remind us one of the most effective prevention tools for Aviators is professionalism. When professionalism fails, there are always signs. Know the Signs. Act on the signs. And prevent the accident from happening.

Until next month, fly safe!

LTC Christopher Prather USACR/SC Aviation Director
email: christopher.prather@us.army.mil

Preliminary Report on FY12 Aircraft Mishaps

In the **manned aircraft** category, Army Aviation experienced 118 Class A-C aircraft mishaps in FY12. This is a decrease from the 123 Class A-C aircraft mishaps in FY11. This also reflects, however, an increase in Class A mishaps (15 in FY11); despite this increase from FY11, we are still on a downward trend from FY09 (25 FY09, 23 FY10).

	2011	2012
CLASS A	15	21
CLASS B	15	15
CLASS C	93	82
TOTAL	123	118
FATALITIES	11	10

CLASS A an B Summary: There were 36 Class A and B mishaps, 15 of which occurred at night. Human Error was the cause factor in 30 (83%) of the 36 mishaps. Materiel failure or suspected materiel failure was contributing in 5 (14%) of the 36 mishaps. Two were listed as unknown or not yet reported.

The Flight category Class A mishap rate for FY12 was 1.68 (1.68 class A mishaps per 100,000 hours of flight time). For FY 11, the rate was 1.10.

Operational Assessment Concerns:

Human Error: 4 Class A and 6 Class C aircraft mishaps occurred during dust landings, with 5 additional Class C events occurring during environmental training. Power management/aggressive maneuvering contributed to 5 Class A or B incidents. One NVG Class A (4 fatalities) occurred due to spatial disorientation with low illumination and lack of terrain contrast as contributing factors. Additionally, there was one NVG mid-air collision (4 fatalities), two UH-60 ground taxi mishaps, two aerostat tether strikes, and two personnel struck by the main rotor blades during ground operations (1 fatality). There was one fatality when a soldier was struck by rotor wash-induced falling debris.

Materiel Failures: Materiel failures included three engine malfunctions, and one suspected main rotor blade de-bonding.

2012 Breakdown by Aircraft Type:

	Class A	Class B	Class C
UH/MH-60	7	6	30
AH-64	3	4	7
CH/MH-47	5	1	16
OH-58D	2	0	11
LUH-72	0	0	1
TH-67/OH-58A/C	1	2	5
AH/MH-6	0	1	6
Mi-8/17	1	1	0
C-12/UC-35	1	0	6
EO-5C	1	0	0

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Synopsis of selected accidents (APR – SEP 12) ** denotes night mission:

Manned Class A

** CH-47D. During an NVG up-slope landing in the vicinity of the landing zone, the Common Missile Warning System (CMWS) was unintentionally activated, causing numerous flares to deploy. The PI reacted by displacing the cyclic control forward, driving the forward rotor disk into the ground. The rotor system became unbalanced and desynchronized, causing significant aircraft damage and four minor injuries.

** UH-60L. During NVG MEDEVAC chase mission with zero illumination and low contrast terrain, aircraft crashed due to spatial disorientation resulting in four fatalities.

- UH-60L. Aircraft crashed conducting a passenger drop-off in a non-standard HLZ. Class A damage reported.

- OH-58D. Mission was aborted following illumination of an Engine chip light. During RTB the engine failed. Aircraft crashed on landing with both pilots sustaining injuries.

- UH-60A. Flight Related. Soldier was fatally injured while photographing hoist training. Soldier was struck in the head by a tree branch knocked loose by the aircraft's rotor wash.

** HH-60L. On MEDEVAC mission, aircraft contacted rising terrain. Post-crash fire ensued. Crew was able to egress the wreckage with one injury requiring hospitalization.

- Mi-17V1. Aircraft crashed upon entering a non-recoverable state of flight at the end of a pinnacle approach, while under a limited power condition.

- OH-58C. Aircraft contacted the ground during an autorotation. Aircraft came to rest on its side. Class A damage reported.

-CH-47D. Aircraft entered dynamic rollover during dust landing.

** CH-47D. Aircraft landed hard during exfil landing under NVGs. Aircraft came to rest on its left side with post-crash fire.

- RC-12P. Left main landing gear collapsed on landing. Class A damage reported.

In the **unmanned aircraft systems**, there were 46 Class A–C incidents with 9 Class A's, 10 Class B's, and 27 Class C's. The Class A's included two Aerostat balloons, five MQ-1s, one MQ-5B, and one YMQ-18. The RQ-7Bs comprised 24 of the 37 Class B and C mishaps with cause factors relating to engine failures, landing problems, and lost link.

Synopsis of selected accidents (APR – SEP):

UAS Class A

-YMQ-18A. Vehicle crashed following loss of power.

- Aerostat. During lowering, PTDS broke free. Recovered with damage.

- MQ-1C. Engine failed, resulting in hard landing on the runway.

- MQ-1C. Vehicle crashed following uncommanded descent during climbout.

- MQ-1C. Vehicle struck mountain during descent. Suspect lost link.

- Aerostat. Balloon descended into concertina during high winds.

- MQ-1C. Vehicle registered high oil temp followed by engine failure.

Crew Coordination

CW5 Dwight L. Greenland
Directorate of Evaluation and Standardization
U.S. Army Aviation Center of Excellence
Fort Rucker, AL
Scout Branch Chief

So there I was, a newly assigned WO1 participating in my first Air Assault mission. All the training and drilling endured over the last fifteen months of flight school and RL progression within the unit prepared me for this very moment. I was a finely honed product of the best rotary wing training in the world ready for my first mission. My mission that day was to monitor the standby load meter. I tackled my mission with the zeal of any new aviator, eyes glued to the gauge watching for any fluctuation of that small needle. The last thing I wanted was to let down my pilot in command, the steely eyed CW4 instructor pilot with a sour temperament and a combat patch from some division that was deactivated decades ago. My role as a crewmember in the aircraft was clear: I was to take no action which may interfere with the pilot in command's duty to single-handedly execute the mission. Any small amount of assistance I could contribute to the mission would not be recognized until I had silently provided weight and balance conformance to enough missions to be considered worthy of actually touching something inside the aircraft other than my armor protected seat. I was, after all, brand new to the unit, how could I possibly contribute to the safe operation of an aircraft and execution of the mission?

My story of progression and integration into crew coordination was the norm for the time, echoed by generations of colored hats trained at Ft Rucker. Fortunately for us, Army leaders correlated the high accident rates due to communication failures and workload priority failures and developed a plan. Aviation Crew Coordination Training began in earnest in the early 90's. Aircrew Training Manuals implemented specific portions of procedures dedicated to communicating between crew members. An entire chapter in each ATM dedicated to Crew Coordination first familiarized all aviators with the definition of, "The action and interaction of crew members for the safe, timely, and efficient completion of all assigned tasks." Instructor pilots attended mandatory Crew Coordination Instructor Training, and evaluation procedures and techniques were developed. IERW classes contained blocks of instruction on Crew Coordination to implement skills from the very beginning of flight training.

Evolution of Crew Coordination concepts lead to the development of the current system of Air Crew Coordination Training – Enhanced, ACT-E. Topics of ACT-E combine to form a relationship of Aircrew Coordination Principles, Quantities, and Objectives. Qualities combine to form the Principles, which when combined produce Objectives. As the ACT-E graph depicts, Qualities, Principles, and Objectives relate to one another in the concept that effectively utilizing the qualities in turn strengthens the principles, and meets the objectives. Conversely, a breakdown in just one Quality weakens one or more Principles which then results in failing to meet he Objective. As the example shows, the quality of "Announce and Acknowledge Decisions and Actions" relates to the principle of "Communicate Effectively and Timely" which meets the objective of "Establish and Maintain Team Relationships". As a review of the qualities, principles, and objectives:

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Qualities:

1. Announce and acknowledge decisions and actions.
2. Ensure that statements and directives are clear, timely, relevant, complete, and verified.
3. Be explicit.
4. Direct assistance.
5. Prioritize actions and equitably distribute workload.
6. Situational awareness.
7. Mission changes and updates.
8. Offer assistance.

Principles:

1. Communicate effectively and timely.
2. Sustain a climate of ready and prompt assistance.
3. Effectively manage, coordinate, and prioritize planned actions, unexpected events, and workload distribution.
4. Provide situational aircraft control, obstacle avoidance, and mission advisories.

Objectives:

1. Establish and maintain team relationships.
2. Establish and maintain efficient workloads.
3. Exchange mission information.
4. Cross monitor performance.

Instilling the concepts of crew coordination begins at the earliest stages of an Army Aviator's career. Within the last year, the development and implementation of the Aircrew Coordination Training – Basic (ACT-B) began for IERW students. ACT-B focuses on training Flight School students on forming positive crew coordination habits beginning with the Primary Phase of Flight Training. Classes contain exercises in verbal and non-verbal communication, stressing the use of standardized terms and engaged discussion. Even before the "nickel ride", students receive valuable instruction in crew coordination. The training continues throughout one's time at Ft. Rucker as instructors at the flight line evaluate crew coordination daily as crew coordination is woven into all flight tasks. Flight tasks contain specific verbiage in the description of maneuvers which through exercise and meaningful repetition become rock solid in new aviators. The framework is set for new aviators to act as an effective crew member upon arrival to their first unit.

The requirement shifts to the gaining unit to sustain and build upon the crew coordination Principles. Sustainment training within the unit utilizes vignette-based presentation. ACT-E facilitators within the unit utilize specific aircraft scenarios to spawn discussion of crew coordination successes and failures utilizing the Qualities, Principles, and Objectives. The concept of a group discussion further develops the climate of efficient flow and exchange of information within the unit which also transitions well into the aircraft. Commanders have the flexibility of tailoring the annual ACT-E requirement to maximize unit involvement or training opportunities. A major element in sustainment of crew coordination is command climate. In order to meet the four ACT-E Objectives, an environment must exist that allows for the candid but constructive exchange of information.

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After action reviews continue to play an important role in evaluating the effectiveness of mission accomplishment and identifying areas of improvement. For crew coordination an example of Objectives met during an AAR would be placing the Objectives into a question. DID WE as a crew establish and maintain team relationships? DID WE establish and maintain efficient workloads? Was mission information exchanged? DID WE as a crew cross monitor performance? If the climate of candid and positive communication exists, specific strengths or weaknesses can be highlighted to improve future mission accomplishment.

The truest test of crew coordination occurs in the aircraft. Every member of a crew has a personal interest in the safe operation of the aircraft. Each has a positive involvement and contribution in the function of the crew regardless of experience, and capabilities well beyond monitoring the standby load meter.

Recently, questions from the field were raised on the proper procedures for conducting and documenting ACT-E training. TC-3-04.11 chapter 4-60 outlines the requirements for ACT-E. Qualification for Rated crewmembers occurs in flight school after 2005. All other crewmembers, including flight school graduates, before 2005 receive initial qualification training by an ACT-E instructor using the most current USAACE approved qualification course, which is available through the U.S. Army "Blackboard" server. Once qualified, crewmembers require training each ATP year using the vignette-based presentation facilitated by an ACT-E instructor. TC 3-04.11 further details the training requirements and personnel authorized to conduct training. Finally, after all ACT-E training is complete, ensure its properly documented on the 7122. If it's not documented, it may as well never occurred.

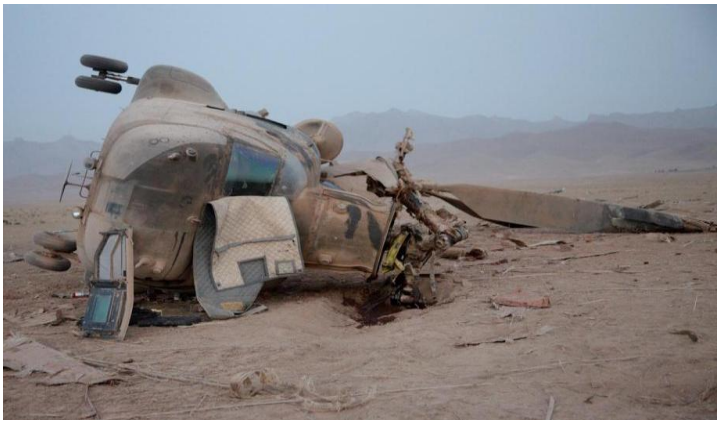
--CW5 Dwight Greenlund, Fixed Wing Branch Chief, Directorate of Evaluation & Standardization, COMM: (334) 255-2453

Relationship of Aircrew Coordination Principles, Qualities, and Objectives

Qualities: 1. Announce and Acknowledge Decisions and Actions.	2. Ensure that statements and directives are clear, timely, relevant, complete, and verified.	3. Be explicit.	4. Direct Assistance.	5. Prioritize Actions and Equitably Distribute Workload.	6. Situational Awareness.	7. Mission Changes and Updates.	8. Offer Assistance.	Principles	Objectives: 1. Establish and maintain team relationships.	2. Establish and maintain efficient workloads.	3. Exchange mission information.	4. Cross-monitor performance.
X	X	X						1. Communicate effectively and timely.	X		X	
			X		X		X	2. Sustain a climate of ready and prompt assistance.	X	X		
	X		X	X				3. Effectively manage, coordinate, and prioritize planned actions, unexpected events, and workload distribution.		X		X
					X	X	X	4. Provide situational aircraft control, obstacle avoidance, and mission advisories.			X	X

Mishap Review: NVG Troop Extraction

While landing to conduct a NVG troop extraction under zero illumination conditions, the CH-47D drifted aft followed by a left drift and roll. The fore and aft rotor discs struck the ground simultaneously, resulting in significant aircraft damage and minor injuries to the crew.



History of flight

The mission was a NVG two-ship insertion of ground forces into an HLZ approximately 8 miles from home base followed by an on-call extraction approximately 3 hours later. The crews began their duty day at 1800L with pre-flights and aircraft run-ups. Mission brief was conducted at 2000L followed by crew briefs at 2030L. The weather was few clouds at 10,000 feet; visibility 5000m with blowing dust; winds 350/09 knots gusts to 15. Temperature was +24C and PA of +6300 feet. The illumination for the flight was 0%.

The flight departed at 2300L with the accident aircraft in the lead position. The infil portion of the mission was successfully completed at approximately 2315L with the lift team returning to base to await the second portion of the mission. At approximately 0245L the flight departed their FOB en route to the exfil location to extract ground forces. Less than 10 minutes later, the flight set up for landing to the northeast to an unimproved HLZ with moderate dust conditions and level terrain. During the VMC approach, dust was called at the cabin doors by both door gunners at approximately 15 feet. The FE (right door gunner) began to call the aircraft down from 10 feet. At the 8 foot call-out the FE announced the aircraft drifting aft, followed by a left drift and left roll. The aircraft continued to roll to the left and the fore and aft rotor discs struck the ground with the aircraft coming to rest on its left side.

Crewmember experience

The PC, sitting in the left seat, had more than 2500 hours total flight time, with 2200 in the CH-47D (1200 as a PC/MP) and 600 hours NVG time. The PI, flying in the right seat, had 2100 hours total time, 390 hours in the CH-47D and 350 hours NVG time. The FE in the right cabin door had 670 hours with 260 NVG. The door gunner in the left cabin door had 245 total hours with 88 NVG. The CE, located on the ramp, had 430 hours with 260 NVG.

Commentary

The accident board determined the pilot on the flight controls failed to maintain and recover orientation on short final due to loss of visual reference and failed to perform a go-around or continue forward and down upon loss of visual cues. The PC failed to closely monitor and prevent the PI from over-controlling and make corrections regarding the PI's inability to recover orientation.

AH-64D Five Year MishapTrend Review

During the last five Fiscal Years (FY08 – FY12), there were 11 recorded AH-64D Class A mishaps resulting in 4 fatalities. Additionally, there were 15 Class B and 60 Class C mishaps. A review of the mishaps reveals the following:

- 8 (64%) of the 11 Class A mishaps were caused by human error. 3 (27%) had materiel failure as causal factors. Class B's consisted of 7 human error and 8 materiel failures. Of the 60 reported Class C mishaps, 63% involved human error, 30% involved materiel failure, and 7% were bird strikes.

Leading mishap events (Class A)

▪ **Power management/excessive maneuvering**. There were five accidents associated with the aircraft running out of power for the conditions/maneuver being performed or appropriate power was applied too late to be effective. (1) One accident occurred when the aircraft contacted the ground during a descending turn. (2) Another when conducting a VMC NVS approach to a 12,200 foot pinnacle. The aircraft's rotor RPM decreased and the aircraft settled and impacted the terrain. (3) On a MTF, when the aircraft was placed in a downwind OGE hover, the aircraft settled and impacted the ground, resulting in injuries to the front seat pilot. (4) Following mission completion, an AH-64D crashed during a return to target type maneuver at high altitude. (5) While conducting a reconnaissance mission in mountainous terrain, the aircraft descended and impacted the ground resulting in total loss of the aircraft and one fatality.

▪ **Materiel failure.** There were three materiel failure mishaps, resulting in two fatalities. Fatigue failure of the mast base support assembly caused the main rotor to impact the forward fuselage, which resulted in fatal injuries to the front seat pilot. In another accident, the FMC commanded BUCS ON in the ROLL channel on short final. Aircraft rolled abruptly and crashed. Lastly, on an air movement security mission the #1 engine oil pressure low caution message sounded. The aircraft could not maintain altitude and impacted the ground with one fatality.

▪**Wire strike.** One wire strike mishap occurred when the aircraft struck a ferry cable obstacle during a day cross-country training flight. The front seat pilot sustained fatal injuries upon impact with the cable and the rear seat pilot successfully landed the aircraft.

▪**Additional.** An AH-64D crashed following loss of tail rotor thrust resulting from a break in the drive shaft. Maintenance had failed to properly torque the #5 tail rotor drive shaft bolts, resulting in a failure of the aft hanger bearing. Another mishap occurred when a suspected over-torque of the main rotor hub nut retention ring at the factory created improper pre-loading of the bearings and led to a catastrophic bearing failure and overheating of the static mast. The aircraft sustained major damage during landing with limited control authority.

	AH-64D CLASS A – C Mishaps			
FY	Class A	Class B	Class C	Army Fatal
2008	0	2	10	0
2009	2	3	17	1
2010	3	3	7	1
2011	3	3	19	1
2012	3	4	7	0
Total	11	15	60	3

Class A – C Mishap Tables

	Manned Aircraft Class A – C Mishap Table									
	Month	FY 12					FY 13			
		Class A Mishaps	Class B Mishaps	Class C Mishaps	Fatalities		Class A Mishaps	Class B Mishaps	Class C Mishaps	Fatalities
1st Qtr	October	2	2	6	1		1			
	November	1	0	13	0					
	December	2	2	6	4					
2nd Qtr	January	2	0	11	0					
	February	2	1	6	0					
	March	1	2	11	0					
3rd Qtr	April	2	1	5	4					
	May	1	0	3	0					
	June	1	0	2	0					
4th Qtr	July	4	3	10	1					
	August	2	4	7	0					
	September	1	0	2	0					
	Total for Year	21	15	82	10	Year to Date	1			

as of 12 Oct 12

UAS Class A – C Mishap Table									
	FY 12 UAS Mishaps					FY 13 UAS Mishaps			
	Class A Mishaps	Class B Mishaps	Class C Mishaps	Total		Class A Mishaps	Class B Mishaps	Class C Mishaps	Total
MQ-1	5	1		6	W/GE		1		
MQ-5	1		2	3	Hunter		1		
RQ-7		5	19	24	Shadow			1	
RQ-11			1	1	Raven				
MAV									
YMQ-18	1			1					
SUAV			5	5	SUAV				
Aerostat	2	5		7	Aerostat				
Total for Year	9	11	27	47	Year to Date		2	1	

as of 12 Oct 12

Who pays the price?

The following article is adapted from a presentation made by Colonel Edward E. Waldron II, commander, Army Safety Center, at the Army Aviation Training Symposium/Policy Committee Meeting at Fort Rucker, November 1981.

The single greatest drain on aviation resources continues to be crew-error mishaps. The persistence of the crew-error problem in a widely varying aviation environment is cause for great concern.

Generally speaking, almost 80 percent of all Army aircraft mishaps involve crew error. This percentage has remained virtually constant for 20 years.

The record shows that the proportion of mishaps involving crew error has not varied more than 10 percent since 1958 while:

- Aviation operations changed from peacetime to combat and back to peacetime.
- Annual flight time ranged more than 5 million hours from the highest to the lowest year.
- The number of aircraft mishaps ranged more than 1,000 from the highest to the lowest year.

FY 81 was a continuation of the same sad story. Analysis of the 43 Class A mishaps during fiscal 81 showed that the cause factors were neither new nor unique. Commanders and aviators just found new ways to repeat the same old mistakes and caused so-called "new" mishaps. In almost every case, the errors causing the mishap were the result of the people involved, failing to do their jobs by the book. The mishaps were spread almost uniformly through the whole range of flight experience and across all the aircraft systems.

Seventy-seven percent of last year's Class A mishaps were caused by errors made by flight crews, instructor pilots, flight commanders, mission commanders, and unit commanders. The dominant factors appearing with alarming regularity were a breach of flight discipline on the part of aircrews and a persistent indifference on the part of commanders and supervisors.

Supervision, source of the problem

Traditionally, the blame for crew-error mishaps has been laid on the person at the controls of the aircraft at the time of the crash – usually the pilot. We feel this blame has been misdirected and, as a result, so have most of our prevention efforts.

Here is the irony of the whole aspect of safety: **Those charged with the responsibility for the safety do not usually pay the consequences when safety supervision breaks down. The flight line mechanics and aircrew members pay the price in full for lack of proper and adequate supervision.** The term "pilot error" has been used to excuse a multitude of actions by commanders which have allowed or set the stage for flight-crew –error mishaps. The bottom line of the crew-error problem is that supervisors are to blame for these mishaps. How else can you explain sending an aircraft with an inoperative artificial horizon on a night mission in marginal weather when fully instrumented aircraft sat on the ramp? The crew, trying to maintain VMC under a low cloud layer, flew the Huey into high tension lines. The pilot was killed and the aircraft destroyed.

How can you explain pairing two young inexperienced aviators in one aircraft in a flight of five when the other aircraft in the formation are piloted by experienced aviators?

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The young aviators were unable to handle a mission which would have tested even experienced crews. They crashed making an ITO in marginal weather and all three occupants were killed.

How can you explain sending a single aircraft into a remote jungle area with the emergency locator transmitter for that aircraft sitting in the supply room instead of being installed in the aircraft? After more than a month of searching at a cost of more than $300,000 for air time alone, we gave up on finding the UH-1 and its three crewmembers.

How can you explain violating crew rest policy on a training mission into marginal weather conditions? The pilot became disoriented and flew the aircraft into the ground, killing himself, the copilot, and the crewchief.

How can you explain a commander allowing a pilot, who was known to bend the rules, to remain on flight status after two flight violations had been filed against him, one for violation of procedures and one for "cowboying" the aircraft? The pilot buzzed several jeeps during a tactical exercise and finally succeeded in crashing into one of them, killing himself and destroying the aircraft.

How can you explain assigning a pilot IP duties on the U-21 after he had failed a standardization checkride in the C-12? Two weeks later, this IP gave a pilot a simulated single-engine failure on final approach and allowed the pilot to put the aircraft in a position from which a safe recovery was impossible. The IP told the pilot to go around. Because of position, altitude, airspeed, and the landing configuration, the go-around was contradictory to procedures. But the pilot tried it anyway. He applied max power to the single operating engine – the IP had not brought the other engine on. This caused the aircraft to roll and yaw left. The IP then reached for the controls, but he was too late.

Supervision, key to the cure

These are not isolated cases. They are typical examples of crew-error mishaps which clearly show that indifferent supervision is the source of the crew-error problem and responsible supervision is the key to the cure.

Regrettably, the accident record shows that flight safety has often been neglected within the overall effort of training a combat-ready force. The rationale for this, characteristically, has been "safety compromises realistic training." While readiness is the primary mission, that mission can only be achieved by combining safety considerations with readiness training. Just as air and ground elements are integral parts of a single force, safety and readiness training work together to provide a combat-ready force. Commanders can become so involved in the tactical scenario they forget that the purpose of realistic training is to produce combat-ready crews and equipment. A smoking hole does neither.

Senior commanders must ensure that subordinate commanders do not use tactical exercises as an excuse to completely disregard flight regulations and sound aviation management principles. Realistic training must be safe training because safety is an integral part of all professional operations. We can't throw safety out the window when we get into combat. We should have learned that lesson in Vietnam. Constant supervision and the elimination of substandard performance is the only way to keep aircrews from destroying aircraft and killing themselves and their passengers. To ignore or fail to correct unsafe acts and unprofessional behavior is a violation of the special trust and confidence placed in commanders.

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Aviation safety depends on commanders. They either push the program or let it slide. It's a command responsibility and those flight line mechanics and aircrews will do whatever commanders decide. They will not practice safety unless commanders show them that violation of safety rules will not be tolerated.

Command action

Commanders have several powerful tools to use to reduce crew-error mishaps. First, improve the direct supervision of all flight operations through personal involvement. Second, increase the discipline of aircrews and force them to operate the aircraft according to regulations and time-proven procedures.

Pilots continue to disregard regulations and procedures, kill themselves and their passengers, and rack up millions of dollars in destroyed and damaged equipment because commanders allow them to get away with it.

Commanders have told me that because they are unable to be present in every cockpit, once the aircraft is off the ground the pilot is on his own. But I feel that even though each commander cannot be physically present in every cockpit on every flight, his presence can be felt in that cockpit. His presence would be the professional attitude that he has established through his own example and the requirements he places on his subordinates and crews.

Suspending pilots and IPs for procedure violations, recording unsafe acts and violations of regulations, and relieving aviators from flying duty with forfeiture of flight pay for flight discipline infractions – these are positive actions commanders may take to improve the discipline and professional performance of aircrews. **If you want to call it arm twisting, go ahead. Whatever its name, it is designed to establish and enforce procedures which in training or in combat will keep professional performance up to maximum levels.**

A great number of aircraft mishaps can be prevented through what is commonly called professionalism, a self-disciplined maturity coupled with competence demonstrated in all aspects of a mission.

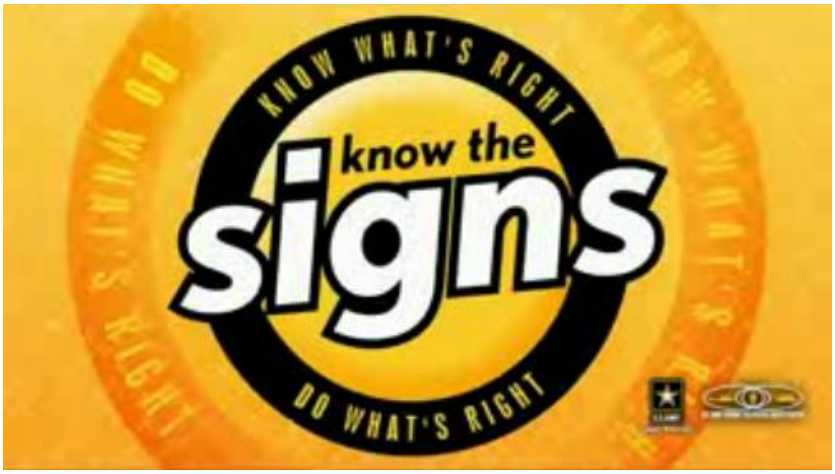
Professionalism is the most essential safety ingredient. Any job done professionally is inherently safe. But if there is no professionalism, there is no safety. Human-error mishaps are especially deplorable because they are preventable.

The commander's special trust is the correction of safety errors before the fact. When senior commanders determine that flight personnel have not had the benefit of a commander who knows and assumes his safety responsibility, then crew error is, in fact, command failure.

Senior commanders won't tolerate failure in supply or maintenance management, or accept poorly trained and equipped soldiers, and above all, will not excuse those who fail to show concern for the welfare of their troops.

Why should Army aviation be any different?

Subscribe to Flightfax via the Aviation Directorate Website: https://safety.army.mil/atf/



CW5 Mike Reese, Chief Warrant Officer of the Army Aviation Branch, is featured in five video PSAs. Four PSAs highlight overconfidence, mission planning, low-risk missions, and indiscipline, and the other highlights seatbelt use. You may view and/or download the PSAs on the USACR/Safety Center public website at the following link:

https://safety.army.mil/multimedia/VIDEOLIBRARY/tabid/419/Default.aspx

NOTICE: Change to Flightfax Subscription Procedures

Some changes have occurred in subscribing to the Flightfax newsletter. Up to this point subscriptions were manually entered into contact lists and Flightfax was manually emailed out to you from a member of the Aviation Directorate. A new program has been installed allowing automatic mailing lists to be generated as well as distribution of new issues. An automatic unsubscribe feature is also incorporated.

Subscribers will sign up on the Aviation Directorate website (https://safety.army.mil/atf/) to receive Flightfax each month by email. You must sign in using your CAC/PIV. Your AKO email address will be entered when you select the subscribe button. An email acknowledging your subscription (with the latest Flightfax issue attached) will be sent to your AKO email address.

AKO email address is the standard. For those individuals without CAC access and/or an AKO email address (sister services, other agencies, etc) the manual contact lists will still be available. Those case-by-case individuals must contact the Aviation Directorate to be subscribed.

Transition glitches. For those individuals who subscribed prior to 6 Sept 2012, you are under the old contacts subscription process. Please re-subscribe under the new system. You have not been dis-enrolled but you may receive two newsletters. Reply to the first mailing stating you are receiving two copies and you will be manually deleted from the old contacts list. Thanks ahead of time for your patience.

Selected Aircraft Mishap Briefs

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

Cargo helicopters

CH-47 

-D series. Left cockpit door separated from the aircraft upon take-off from the airfield. Crew landed the aircraft without further incident and door was recovered. (Class C)

Utility helicopters

UH-60 

-M Series. #2 engine oil–LOW pressure indication during RL progression evaluation. Aircraft landed without further incident. Post flight revealed cap had not been replaced on the oil reservoir. Replaced engine. (Class C)

Fixed wing aircraft

RC-12P 

Crew was conducting an RL progression training flight when they experienced a cockpit warning indication for a left main landing gear anomaly. Crew initiated emergency procedures and the landing gear collapsed upon touchdown. (Class A)

Unmanned Aircraft Systems

MQ-1C 

UA experienced high temp warning on climb-out. Crew executed emergency procedures to return to base. Engine failed with system landing short of the runway. (Class A)

Aerostat 

Aerostat recovered with damage after being observed drifting unsecured. Inspection revealed that the tether had been severed from a suspected aircraft rotor strike. (Class B)

It is impossible to accurately measure the results of aviation safety. No one can count the fires that never start, the aborted takeoffs that do not occur, the engine failures and the forced landings that never take place. And one can neither evaluate the lives that are not lost, nor plumb the depths of human misery we have been spared.

But the individuals with the flight controls, fueling hose, wrench, radar, or work order can find lasting satisfaction in the knowledge they have worked wisely and well, and that safety has been the prime consideration.

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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