

# Flightfax<sup>®</sup>



**Online Report of Army Aircraft Mishaps**

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This Flightfax contains a preliminary report on the 1st Half of FY13 aircraft mishaps. For the first half of FY13, we've experienced 31 Class A-C mishaps; six Class A, three Class B, and 22 Class C. This seems to be an improvement when considering the first half of FY12 with 71 mishaps; nine Class A, eight Class B, and 54 Class C. This comparative improvement has been dampened, though, since it has been a difficult month for safety in Army Aviation with three recent Class A mishaps. The predominant trend you will discern in reviewing the preliminary report is human error. Five of the six Class A mishaps and all three of the Class B mishaps, a staggering 89%, were the result of human error.

Once again in Flightfax, we are pointing out human error as a significant recent trend in Aviation mishaps. This may be a result of an approach to completely eliminate human error, which alone may not be totally effective. Attempting to completely eliminate human error is extremely difficult, if not impossible. This is not meant to convey that a goal of elimination of human error is not a completely worthy goal, or that attempts to reach that goal are not effective prevention techniques. Human error occurs every day, and is seldom catastrophic or fatal; this is a testament to your excellent safety and standardization programs. On the other hand, believing that our programs can make human error extinct may actually lead to crews not prepared to comprehend what is occurring and take action when human error happens. Worthy of further consideration is the idea that as opposed to applying a prevention technique centered on eliminating inevitable errors and system failures, perhaps our safety programs would be even more effective if we enhance training and mitigation to include recovering from human and material failures.

Human mishaps are a fact of life. Unlike our amazing and very capable aircraft, people are not precision machinery designed for accuracy. In fact, we humans are an entirely different kind of machine. It is because of our human creativity, adaptability, and flexibility that we are amazingly error tolerant – because we have the ability to move beyond error. We are superb at finding explanations and meanings from partial and noisy evidence, which is to say that we are extremely flexible, robust, and creative. The same aspects in our nature that lead to such robustness and creativity also produce errors. Our natural tendency to interpret partial information - which is a critical ability for creativity - can cause aviation Soldiers to misinterpret system indications or crewmember behavior in such a plausible way that the misinterpretation can be difficult to overcome or un-do in the cockpit.

Nowhere in life can mistakes be made impossible. In light of this, Wickens et al (1998) outline that human error and their negative consequences are mitigated in one of three ways: system design, training, and personnel (crew) selection. While crew selection and training are extremely important factors, we know that even the best-trained and standards-adhering pilot will still make mistakes. What does this mean? It means that despite our most refined crew selection, mission approval, and briefing process mitigation - even if perfectly executed IAW AR 95-1 - bad things will still occur.

Enhancing training to be inclusive of error recovery, rather than just error prevention, will make a more successful pilot. This could mean after training to eliminate miscommunication in ACT-E, an effective next step and practice may include what to do once miscommunication occurs; how to go beyond the event and apply and use our strengths of creativity and troubleshooting with limited information. Or, conducting simulator training in recovering from - and keep from turning catastrophic - a screw up from another crewmember or non-rated crewmember or a mechanical failure.

Aviation Soldiers commit errors every day, but not all result in catastrophic and fatal events. The key, perhaps, is going beyond not just diagnosing what went wrong in a catastrophic event, but also finding out what went right in the hundreds of non-catastrophic failures. We can get beyond our error weakness by applying our strengths through approaching mishap prevention from a creative, flexible, and adaptive point of view so that we can become creatures of a proactive safety culture.

Until next month, fly safe!

LTC Christopher Prather USACR/SC Aviation Director

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Wickens, Christopher D., Gordon, Sallie E., and Liu, Yili (1998). *An Introduction to Human Factors Engineering*. Addison-Wesley Educational Publishers Inc., New York, New York.

Manned Aircraft Class A – C Mishap Table											as of 22 Apr 13
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		
1 <sup>st</sup> Qtr	October	2	2	6	1		1	0	7	0	
	November	0	1	13	0		0	1	3	0	
	December	2	2	6	4		2	1	0	0	
2 <sup>nd</sup> Qtr	January	2	0	11	0		0	0	6	0	
	February	2	1	6	0		0	0	2	0	
	March	1	2	12	0		3	1	4	7	
3 <sup>rd</sup> Qtr	April	2	1	6	4		1	1	4	2	
	May	1	0	4	0						
	June	1	0	2	0						
4 <sup>th</sup> Qtr	July	3	3	9	1						
	August	2	5	5	0						
	September	2	0	2	2						
	Total for Year	20	17	82	12	Year to Date	7	4	26	9	

# Preliminary Report on 1<sup>st</sup> Half FY13 aircraft mishaps

In the **manned aircraft** category, Army aviation experienced 31 Class A - C aircraft accidents this fiscal year. These accidents resulted in seven fatalities. Six of the accidents were Class A's, three were Class B's, and 22 were Class C's. For comparison, the first half of FY12 had 71 Class A - C aircraft accidents - nine Class A's (five fatalities), eight Class B's, and 54 Class C's.

For the first half of FY13, five of the six Class A mishaps and all three of the Class B mishaps were the result of human error (89%). Over half of the 9 Class A and B mishaps occurred at night. Materiel failure (engine failure) was contributing in one Class A. There was one lightning strike Class C and one deer strike after landing (C-12). Five of the 9 Class A and B mishaps occurred in OEF.

Dust landings were contributing factors in one Class A and one Class B mishap. Additionally, there was one Class A UH-60 ground taxi incident, one Class B wire strike, and three tree strikes (all Class C).

	<u>Class A</u>	<u>Class B</u>	<u>Class C</u>
UH/MH-60	3	1	9
AH-64	0	0	2
CH/MH-47	2	1	3
OH-58D	1	0	3
LUH-72	0	0	2
TH-67/OH-58A/C	0	1	0
AH/MH-6	0	0	0
<u>C-12/C-26</u>	<u>0</u>	<u>0</u>	<u>3</u>
Total	6	3	22

Synopsis of selected Class A accidents (OCT - MAR 13). N/NVD denotes night/night vision device mission:

## **Manned Class A**

-CH-47D. Aircraft struck a VSP tower during landing in dust sustaining damage to the forward main rotor system.

-UH-60A. During ground taxi to a civilian refueling point, the aircraft's main rotor blades contacted a hangar resulting in damage.

-UH-60M (NVG). Main rotor blade struck upslope terrain during a pinnacle landing.

-CH-47F (NVG). Flight related. Fatality to a soldier on the ground occurred when a large gate was toppled by rotor wash during a sling load operation.

-UH-60L (NVG). Aircraft crashed during RL progression flight. Five fatalities (See Mishap Review in this issue.)

-OH-58D. Aircraft crashed following engine failure. One fatality. (See mishap review in this issue.)

In the **unmanned aircraft systems** for the first half FY13, we experienced 19 Class A-C incidents with four Class A's, one Class B, and 14 Class C's. For the same time period in FY12

there were two Class A's, four Class B's, and 18 Class C mishaps. The four FY13 Class A's were two MQ-5B Hunters and two MQ-1C Gray Eagles. The lone Class B was a RQ-7B Shadow. There were 14 UAS Class C category mishaps with seven RQ-7s, three MQ-5s, and four RQ-20A Puma's. Of the 19 total UAS Class A-C mishaps, eight were RQ-7B Shadows. The predominant cause factor for UAS mishaps was engine malfunction.

	<u>Class A</u>	<u>Class B</u>	<u>Class C</u>
MQ-1C Gray Eagle	2	0	0
MQ-5B Hunter	2	0	3
RQ-7B Shadow	0	1	7
RQ-20A Puma	0	0	4
Total	4	1	14

Synopsis of selected accidents (OCT 12 – MAR 13):

### UAS Class A

-MQ-1C. Operators experienced engine oil/coolant and gearbox over-temp and FADEC fail indicators during flight. Crew attempted to land to the runway and experienced engine failure. The UA impacted just off the runway.

-MQ-1C. System experienced an engine failure indication during manual transfer of fuel operation. Engine restarts were attempted with no success. UA crashed and was destroyed on impact.

-MQ-5B. Operators experienced engine RPM fluctuations during flight at 7,000 feet AGL. The system continued to lose RPM until the engine failed at 2,000 feet. Wreckage was located and destroyed in place.

-MQ-5B. While on take-off under the ATLS, UA traveled approximately 250' before it veered off the runway into a concrete drainage ditch. System sustained significant damage.

UAS Class A – C Mishap Table									
as of 23 Apr 13									
	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	2	0	1	3
MQ-5	1		2	3	Hunter	2	0	3	5
RQ-7		5	20	25	Shadow	0	1	8	9
RQ-11			1	1	Raven				
RQ-20			4		Puma	0	0	4	4
YMQ-18	1			1					
SUAV			1	5	SUAV				
Aerostat	2	5		7	Aerostat				
Total for Year	9	11	28	48	Year to Date	4	1	16	21



# Mission Briefing Process

DAC Charles W. Lent

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Fort Rucker, Ala.

H-60 SP/IE, Literature Review

**Amy Regulation (AR) 95-1, paragraph 2-14, mandates requirements for the Army Aviation Mission Approval Process. In a vast number of aviation accidents aircrews met the requirements of the procedures but missed the intent of the process. In many cases Mission Briefers are not interacting with the Pilot in Command (PC) and Air Mission Commander (AMC) and effectively mitigating risk. When the important questions are not asked, or a link in the chain of events leading to an accident is not broken, it often leads to catastrophic results.**

In 2006, the Mission Approval process was mandated by the Army and integrated into AR 95-1. Since that time it has been embraced by Army Aviation units and become a familiar part of daily business. The direct involvement of Commanders was required, based on information that proved successful Commanders were involved in the unit's mission. The procedures for risk acceptance by the appropriate risk level authority in the chain of command were officially formalized and required written documentation on the DA Form 5484 Mission Schedule/Brief. Prior to 2006, the mission approver and the briefer were one and the same. The intent of separating the mission briefer from the approver was to infuse the process with a Pilot in Command with an in-depth understanding of the unit's mission. This includes a thorough knowledge of mission planning, mission execution, rules and regulations and, most importantly, the experience to recognize when important details were missed in order to mitigate risk. The findings of many aviation accidents determined a breakdown of the mission approval process as a significant contributing factor.

AR 95-1 requires that Commanders establish a training and certification program to ensure standardization and an understanding of the mission approval and risk management process for those responsible for Initial Mission Approval Authority, Mission Briefer and Final Mission Approval Authority responsibilities. The intent of the training and certification is to ensure that designated personnel have a thorough understanding of the process and be able to properly assess and mitigate risk for the command before the risk is accepted by someone in the chain of command. In many instances this is not the case and the training is relegated to a PowerPoint slideshow once a pilot makes PC and added to the list of mission briefers. Many times the training is not documented in the Individual's Aircrew Training Folder and, therefore, not a surprise when mission briefers do not know the minimum required questions to ask during a mission briefing. Mission briefers should be selected based on their experience, maturity, judgment, and ability to effectively mitigate risk. One could make an argument that selecting all PCs to be briefers, while allowing easy access to receive a briefing, may not meet the criteria of experience in the mission profile.

***It should be very clearly stated that getting initials on the DA form 5484 and meeting the***

Continued on next page

**requirements to complete the form is not meeting the intent of a mission briefing process.** In many cases the minimum required questions or, more specifically, the right questions pertinent to the mission are not being asked by the mission briefer. VOCO authorization is often obtained and there is no interaction between the briefer and PC/AMC. While VOCO authorization is allowed, it should not be the norm based on the fact that it is nearly impossible to review and assess mission planning over a phone or through a third party. Approval authorities do not have an interaction requirement with the PC or AMC, so it is critical the mission briefer analyze the details of the mission. When the mission briefer does not review the details of a mission the required risk mitigation does not happen and the intent of the process fails. AR 95-1 states that **Interaction between crew and briefer is paramount to identify, assess, and mitigate risk for the specific flight or mission.** Briefing officers are responsible for ensuring key mission elements are evaluated, briefed and understood by the mission pilot in command or Air Mission Commander. **At a minimum, mission briefing officers will review and assess the following key areas** in the mission planning process:

1. The flight is in support of an operational unit mission.
2. The crew understands the mission and possesses situational awareness of all tactical, technical and administrative mission details.
3. Assigned flight crews have been allocated adequate pre-mission planning time and the mission is adequately planned to include performance planning, notices to airmen (NOTAMs), and coordination with supported units.
4. Assigned flight crews are qualified and current for the mission in accordance with this regulation and the commander's flight crew qualification and selection program per paragraph 4-18, to include ALSE with current inspections, air crew reading file currency, and crew experience appropriate for the mission.
5. Forecast weather conditions for the mission, including departure, en route and arrival weather, meet the requirements of this regulation and local directives.
6. Flight crews meet unit crew endurance requirements.
7. Procedures in the commander's risk management program are completed and mitigated to the lowest level possible.
8. Required special mission equipment is operational.

**The mission briefer is an integral part of the Mission Approval process and required by AR 95-1 to perform a detailed analysis of the mission in order to mitigate risk for the command. When a detailed mission briefing is not performed by an experienced PC the process fails allowing aircrews and the command to assume more risk than necessary. The mission briefer must be able to mitigate risk in order to break the chain of events that may lead to an aircraft accident. Meeting minimum requirements to complete DA form 5484 should not be confused with conducting a detailed analysis of mission planning and the required application of minimum requirements for the mission IAW AR 95-1.**

**--DAC Charles W. Lent may be contacted at (334) 255-9098, DSN 558.**

# Mishap Review: NVG RL Training

**While conducting multi-aircraft NVG RL progression training in a low illumination/low contrast environment, the UH-60L entered a right roll and impacted the ground resulting in five crewmember fatalities and a destroyed aircraft.**



## History of flight

The mission was a day, night and NVG RL progression training flight for a newly assigned PI and two 15T crewmembers. This was the PI's fourth RL training flight and the first for NVG refresher training. The moderate risk mission was approved by the task force commander the day prior to the scheduled training. The weather forecast included ceilings at 7,000 feet; visibility 9000m with light rain and mist; winds 270/05 knots. Illumination for the flight was 0 percent. Aircrews reported there was moderate to heavy rain in the area at the time of the accident.

The accident crew's show time was 1500 hours. Takeoff for the day training was approximately 1700 hours. The aircraft landed at 1830 hours. Following two hours of ground time the crew departed at 2030 hours for NVG training. Initial pattern work was conducted followed by hot refuel. 45 minutes after takeoff, the aircraft joined with a sister ship (which was also conducting single-ship training) to perform formation flight training en route to the test fire area to fire the door guns.

The flight of two departed the airfield at 2124 hours with the accident aircraft as Chalk 2 in a staggered left formation. En route altitude to the test fire area was 1500 feet AGL with an airspeed of 100 knots. Upon arrival, the area was occupied by two OH-58Ds conducting test fires with illumination rockets and .50 cal. Flight lead communicated the intention of holding in a right hand orbit and reducing speed to 80 knots to wait for the range to clear. Following one complete turn in the orbit the aircraft entered a nose low steep right turn with a rapid descent until ground impact. The aircraft was destroyed and all five crewmembers were fatally injured.

## Crewmember experience

The IP, sitting in the left seat, had more than 1,250 hours total flight time, with 1,170 in the UH-60 (286 as an IP) and 384 hours NVG time. The PI, flying from the right seat, had 431 hours total time, 349 hours in the UH-60 and 39 hours NVG time. The FI, located in the main cabin, had 620 hours with 243 NVG. The door gunner in the left crew position had 97 total hours documented with 38 NVG but had previously been on flight status as a crew chief. The CE, located in the right crew position, had 11 total hours with two hours NVG.

## Commentary

The accident board determined that while conducting NVG formation flight as Chalk 2, in a right hand orbit with low illumination and no visible horizon, the crew failed to maintain orientation and lost spatial awareness. The aircraft was placed into an unrecoverable attitude and impacted the ground destroying the aircraft and fatally injuring all five crewmembers. Additionally, the board determined the mission briefing process failed to properly identify and mitigate risk for the flight. The PI, in the conduct of NVG refresher training, was placed beyond experience and readiness level by performing multi-aircraft operations – a mission training task.

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## ARMY PRELIMINARY LOSS REPORT 13053 AVIATION MISHAP CLAIMS TWO SOLDIERS' LIVES

Two Pennsylvania Army National Guard Soldiers assigned to the 101<sup>st</sup> Combat Aviation Brigade, were killed in an AH-64D Apache Longbow helicopter mishap that occurred on 9 April 2013 at approximately 0900 local in Afghanistan. The crew was the second aircraft in a flight of two when the aircraft struck the ground. Both pilots, a CW3 and CW2, died in the crash. Further details of the crash are not available at this time. A Centralized Accident Investigation (CAI) team from the US Army Combat Readiness/Safety Center is investigating.

This is the 9<sup>th</sup> Class A **Aviation** fatality in FY13 compared to 5 for the same time frame in FY12. 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).

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**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>

## ARMY PRELIMINARY LOSS REPORT 13045 FLIGHT RELATED MISHAP CLAIMS ONE SOLDIER'S LIFE

A 3<sup>rd</sup> Combat Aviation Brigade Soldier died on 13 March after being involved in a flight related mishap that occurred on 3 March 2013 at approximately 0330 local in Afghanistan. The 26-year-old PFC was struck by an 800-pound barrier gate after it was toppled by rotor wash from a CH-47F. The Soldier was transported to a medical center and pronounced deceased after being removed from life support on 13 March 2013. [News Article](#)

This is the 1<sup>st</sup> Class A **Aviation** fatality in FY13 compared to 5 for the same time frame in FY12. 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).

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# Mishap Review: OH-58D Engine Failure

While conducting day, multi-aircraft gunnery training the OH-58D experienced an engine malfunction. The aircraft impacted the ground and came to rest on its right side resulting in one crewmember fatality and destruction of the aircraft.



## History of flight

The mission was a multi-ship RL 2 to RL 1 progression evaluation flight under day, night and NVG conditions. The training incorporated gunnery tasks associated with engaging targets with 2.75 inch rockets and .50 caliber machine guns in a Scout Weapons Team (SWT). The two instructor pilots completed a mission brief and risk assessment the day prior to the scheduled training. The Mission Briefing Officer (MBO) conducted a face-to-face briefing with both IPs and ensured the training for the evaluation flight was understood and correct for the flight. The overall risk was assessed as moderate due to zero illumination conditions and lack of NVG experience. The final approving authority was the squadron commander. The weather forecast was winds at 240/16 gusting to 21 knots; visibility unrestricted; sky conditions few at 5,000 feet; temperature 25 degrees Centigrade.

The accident crew reported for duty at 1130 hours, completed their aircraft preflight and conducted a 'rock drill' walk-through with the crew of the other SWT member. At approximately 1400 hours they received their aircrew mission brief, weather brief and TACOPS/S-2/S-3 updates followed by additional table talk with the two PIs. Upon completion, the crews repositioned to their aircraft and completed run-up procedures.

At 1540 hours the crews completed run-up and communications checks and repositioned to the FARP to upload ammunition. With the accident aircraft in trail position, the SWT departed the airfield at 1600 hours en route to the test fire area. The SWT arrived on station at 1610 hours, completed a range sweep and initiated training. The lead aircraft completed a dry fire engagement using a 040 degree inbound heading. The accident (trail) aircraft began its inbound dry fire engagement as the lead aircraft turned outbound. The trail aircraft completed their dry fire engagement with no noted issues. The accident aircraft executed a right hand turn to an outbound heading of 210 degrees and initiated a climb to 500 feet AGL. On the outbound heading and at an altitude of approximately 400 feet AGL, the low rotor audio tone annunciated, Ng dropped to 78 percent and the aircraft yawed to the left approximately 10-15 degrees. Two seconds after initial indications of a

malfunction, the main rotor RPM decreased to 79 percent and Ng to 68 percent. Nine seconds after the start of the emergency, the aircraft impacted the ground in a 5 degree left side low attitude and came to rest on its right side.

### **Crewmember experience**

The IP, sitting in the left seat, had more than 4,300 hours total flight time, with 4,200 in the OH-58D (1,200 as an IP) and 3,000 hours combat time. The PI, flying from the right seat, had 189 hours total time, 106 hours in the OH-58D and 29 hours combat time.

### **Commentary**

The accident board determined the aircraft experienced an engine malfunction/power loss. Rotor RPM decayed rapidly with accompanying rapid descent and impact with the ground resulting in one crewmember fatality, one critical injury and the aircraft being destroyed. Additionally, the board determined the crew improperly diagnosed/responded to the low rotor RPM indication by not verifying conditions and adjusting the collective immediately to regain rotor RPM.

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# **ARMY PRELIMINARY LOSS REPORT 13047 AVIATION MISHAP CLAIMS ONE SOLDIER'S LIFE**

A 3<sup>rd</sup> Combat Aviation Brigade Soldier was killed in an OH-58D Kiowa Warrior helicopter mishap that occurred on 16 March 2013 at approximately 1630 local in Afghanistan. The crew was conducting a Readiness Level Progression training flight when the aircraft struck the ground. One pilot, a CW3, died in the crash while the other, a 1LT, survived. Details of the crash are not available at this time. A Centralized Accident Investigation (CAI) team from the US Army Combat Readiness/Safety Center is investigating.

This is the 7<sup>th</sup> Class A **Aviation** fatality in FY13 compared to 5 for the same time frame in FY12. 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).

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# Leadership: It's Up To You

Article submitted by CW4 Michael Zinski

As professional aviators, we know the safe and effective employment of Army aviation assets ultimately rests with the individual aircrew. Within the crew structure, the pilot in command has final responsibility for the operation of the aircraft, and leadership failure in the cockpit can have serious consequences.

Years ago, when I took my first check ride to become a pilot in command (PC), my evaluator provided some very specific mentorship which, to this day, I think about before each flight. He made sure I understood the PC was responsible for everything that happened, good or bad.

He made it clear that a leader seeks responsibility and takes responsibility for their actions. The Army evaluates aviators for both technical and tactical abilities along with leadership skills. Besides flying skills, their maturity, discipline and decision making processes are also considered. These last three areas are where leadership abilities are assessed to ensure an aviator is ready to be a PC.

Historically, many aircraft losses not attributed to enemy action were blamed on leadership failures in the cockpit. These failures are categorized as individual failures, but many times they can be characterized as indiscipline or poor decision making. This characterization describes the individual leadership failure in the aircraft, and the ultimate leadership failure of the pilot in command. While the action of any one crewmember can lead to mission failure, the ultimate responsibility for the failure rests with the pilot in command.

These leadership failures are not necessarily tied to the youngest and most inexperienced leaders. A new PC may be overly cautious while an experienced PC may be over confident. Both could lead to bad decisions. When senior leaders make bad decisions, they may reflect an isolated lapse of judgment due to a situation. Also, it could be the result of complacency brought on by their perceived knowledge, a repetitive mission and job performance. Regardless of the experience level of the individuals involved, the base line result is a failure to effectively lead in the cockpit.

Unfortunately, these failures are often brought to light and recognized only after a catastrophe. Not all cockpit leadership failures lead to equipment damage or personal injury, but these are the ones which have the greatest effect on the aviation community because of their high visibility. An important question is how common are the failures which only result in a 'close call' and then are never reported due to the fear of repercussions on the aircrew. Unreported leadership failures can provide negative reinforcement for further failures, or make leaders reflect on their performance and seek improvement. The choice is theirs.

Army aviation needs PCs who instill in others the career value of becoming PCs. It's the door opener to advanced assignments and greater responsibility and must not become a 'rite of passage' or an automatic assumption that, after a certain point in a career, one deserves to be a PC. It must remain a position which aviators strive for through technical and professional excellence.

Those who become PCs must be treated as leaders who accept increased responsibility and understand the need to train and mentor new aviators. Providing ongoing professional leadership-based guidance works to reduce any negative trends or failures in Army aviation.

-CW4 Zinski is currently serving as the Safety Officer for the 204<sup>th</sup> MI Bn (AR), Fort Bliss, Texas

# Blast From The Past

Articles from the archives of past Flightfax issues

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## Briefing the other crewmember 14 Mar 1984 Flightfax

As the designation implies, the pilot-in-command (PIC) of an aircraft is in a command position. The PIC is the commander of the aircraft and assumes a lot of responsibility every time he signs his name to the flight plan. That responsibility covers everything from flight plans to emergency procedures – from crew briefings to passenger briefings. With all of these areas of responsibility, no area seems to be more important than a good crew briefing.

Before a mission, the PIC makes all his plans, then he and the co-pilot talk about the mission, the weather, route of flight, transfer of controls, emergencies, crew communication, radio procedures, etc. After all the appropriate steps are taken before the start of the mission, the PIC and co-pilot preflight the aircraft with the crew chief and continue with the mission. This is how it should be – procedures followed, crew briefed, and mission accomplished.

The crew briefing is an essential part of following procedures, achieving maximum crew communication and accomplishing the mission. That briefing is an important asset available to the PIC for the safe accomplishment of the mission. But wait a minute. Isn't something missing? Isn't there another crewmember who needs to know what's going on?

Let's think about what the PIC did. He very carefully planned his mission, he called in his co-pilot and gave him a thorough briefing, he received his weather and filed his flight plan, both he and the co-pilot preflighted the aircraft with the crew chief . . . That's it, the crew chief! What about briefing the "other crewmember," the crew chief? Doesn't he need to know something about the route of flight, weather, cargo, refueling, emergencies, crew communication, and any special instructions pertaining to the mission? These are just a few of the items that should be related to the crew chief to enable him to be an effective member of the crew. The information given to the crew chief is just as important as the information given to the co-pilot. There are times during the flight when the PIC needs to rely on the crew chief just as he relies on the co-pilot. He should have previously coordinated with the crew chief so there can be maximum communication among the crew.

Consider for a minute the crew communication required in ground taxi operations. Is communication with the crew chief essential? You better believe it is. How about clearing the tail of the aircraft in an NOE environment? Is there a need to communicate with the crew chief? You bet.

At some point during aircraft operations, either today or tomorrow, the PIC will need to communicate with the "other crewmember." Prepare that crewmember by telling him what you expect of him. The time you spend briefing the "other crewmember" will be time well spent.

Enhance crew effectiveness by thoroughly briefing **all** of the crew. The PIC is responsible for briefing the crew. The crew includes the crew chief.

- then CW2 Francis White, 243<sup>rd</sup> Aviation Company (ASH), Fort Lewis, Wash.

# Selected Aircraft Mishap Briefs

Information based on preliminary reports of aircraft mishaps reported in March 2013.

## Cargo helicopters

**CH-47**



-F series. Aircraft was conducting sling-load operations when an 800 pound barrier gate toppled due to rotor wash. The gate struck and pinned a Soldier resulting in fatal injuries. (Class A)

## Utility helicopters

**UH-60**



-L Series. Aircraft crashed during a NVG low illum training flight. Five fatalities. (Class A)

-A Series. Aircraft contacted wires with the WSPS during low level NVG training on an approved training route. Minimal damage reported to the aircraft. Strike resulted in local power outage. (Class B)

-MH-60K. Aircraft contacted a tree during VMC approach to MOUT site. Stabilator and all four main rotor blades sustained damage. (Class B)

-L Series. Aircraft was in cruise flight when the right cockpit door inadvertently jettisoned. Door was not recovered. (Class C)

-A Series. Engine start was attempted with one blade tie-down rope still attached. Damage occurred to both tail rotor paddles, gearbox cover, tail pylon and one main rotor blade. (Class C)

-A Series. Tail rotor paddle experienced separation of the erosion strip and tip cap causing damage to the main rotor system. (Class C)

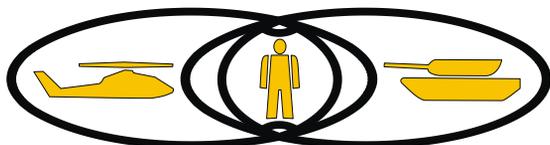
## Attack Helicopters

**AH-64D**



-Aircraft contacted a tree executing an evasive maneuver to avoid a bird strike. Stabilator damaged. (Class C)

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