Number 31 November 2013

Flightfax®

Online newsletter of Army aircraft mishap prevention information

I am honored to make my first entry into Flightfax as I assume the role of Aviation Director, leading the Aviation Directorate in the CRC. I recently left command of 2-3 GSAB in 3CAB at Hunter Army Airfield and hope to continue the great legacy of this directorate in helping our great aviators reduce the accident rates within Army Aviation.

Last month, we celebrated the close of FY13 and the exceptionally low aviation accident rates for the year. This was the culmination of hundreds of thousands of flight hours with pilots in command and air mission commanders making smart decisions on each and every flight they led. Be proud of last year's accomplishments, but the new fiscal year is here, along with several recent incidents showing that aviation is still a dangerous business. Maintaining our historic low accident rates will require every aircrew member to continue to make informed and alert decisions during every phase of their flight while managing their risks down to the lowest levels.

As you read through this edition of Flightfax, think about the risks that the aircrews identified and the controls that they placed upon their mission in the pre-mission process and compare them to the risks they encountered during mission execution. Leaders within Army Aviation are inherently good at the RM process and can identify the individual hazards associated with each mission effectively. However, in my experience, we are less effective during mission execution in identifying compounding hazards, by either not recognizing their risk levels or under-assessing the cumulative effect of these hazards. LCDR Henry's excellent article in this edition highlights his team's Crew Resource Management (CRM) and flight discipline successes that resulted in a successful rescue. It is clear in the article that the crew struggled to accurately judge their risk levels with all the compounding factors required of them in order to complete their assigned mission. What would you have done in these circumstances?

Until next month, fly safe and manage your risk levels!

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Where the Road Ends, Communication Should Begin

LCDR Brian Henry, USCG, Group/Air Station North Bend

On 5 July 2010, I was the PIC during an aircraft mishap that underscored the dangers and leadership challenges of flying in the Coast Guard. I firmly believe that I should share some of my own shortcomings in Crew Resource Management (CRM) and Operational Risk Management (ORM) to help keep you, my fellow flyers, from getting into a similar situation. I will discuss how deficiencies in communication, risk management, flight discipline, leadership, and situational awareness all contributed to a situation in which the crew and the helicopter could have been lost.

The evening of 5 July featured a perfect, fog-free sunset on the Oregon coast. I was standing duty at Air Facility Newport and settling in on my first helping of Espresso Madness ice cream when the SAR phone rang. The call for three juveniles stranded on a rock near Road's End State Park 20 NM to the north. I knew where Road's End Park was, realized that we were running out of daylight, and did not request additional information. In an effort to get these hoists done before sunset, we pushed ahead toward a launch as this appeared to be a detail we could clear up during the 10 minute transit and took off for Road's End.

Once we arrived on scene, our rescue swimmer reported four small specks on a vertical surface that we collectively determined to be people in the faint ambient light. There were two individuals on a western reach of what appeared to be about a 150 foot vertical surface approximately 75 feet above a sandy beach and two more east of the others about 60 feet above the beach. We made multiple recon passes to survey the scene, but did not report the on-scene conditions or the actual nature of the rescue to our Operations Center (OPCEN) in North Bend, Oregon.

External communication with parties outside the aircraft has a key role in facilitating other key components to CRM such as situational awareness. Unfortunately, a hazardous attitude of "I have to get these kids off the cliff, and I can't waste time and fuel to talk on the radio any longer" prevailed. The OPCEN and operations officer were left to assume the case was a simple case of survivors stranded by the tide on a rock and not a night vertical surface rescue we never train for.

After being told that the rescue party was not able to reach the children from the top or bottom of the cliff, we planned to rescue each survivor from a position 200+ feet above the beach to maintain clearance from the upper ridge of the vertical surface, 25 feet of clearance from a group of dead trees to the west of the survivors, and 25 feet of clearance from a 400-foot headland up and to the east of the survivors to minimize downwash and blowing dirt. As a crew, we agreed the mission was extremely high risk, but that there was high gain. I had never performed a night vertical surface hoist, but had excellent NVG conditions and felt that I could maintain a steady platform for my flight mechanic to hoist 120 feet above the clinging survivors.

Inadequate external communications were again a problem in that we never conveyed to local responders the potential negative impact of downwash and blowing debris on the survivors, nor the fact that none of us had conducted a rescue of this nature at night. Instead, I assumed that by asking the ground rescuers multiple times if our services would be required, they would infer that we were worried about the high risk of a helicopter rescue.

We battled as a crew to fight through darkness, downdrafts, and blowing debris to take two of the four children off the cliff and deposit them on the beach below utilizing our rescue swimmer to make contact with each child and apply a quick strop. Both hoists of the rescue swimmer and survivor resulted in violent swings away from the cliff with subsequent swings and brutal contact with the cliff face. As I maneuvered the aircraft aft and away from the cliff, dust clouds billowed up

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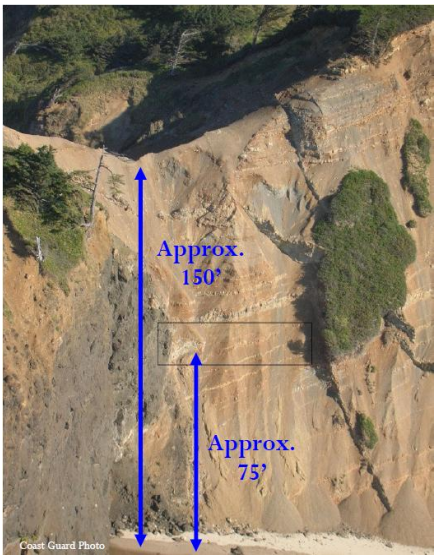
The incident scene. The rectangular box indicates the area in which the victims were trapped.



forward of the aircraft and obscured my 40-degree NVG field of view making it difficult to maintain hover references. The rescue swimmer was brought aboard the aircraft and he announced that he didn't think that there was any way to recover either the third or fourth survivors without knocking someone off the cliff. Low on fuel, we departed scene and again questioned the local responders to see if there was any other way to get to the survivors off the cliff or if the pair could make it through the night on the cliff. They replied that a helicopter rescue would be required.

We recovered at Newport, refueled, and I spoke briefly to my operations officer, who did not know that the case involved a night vertical surface rescue. I told him that the previous two hoists were the hardest I'd ever done and we were "in the red" for risk. What I didn't tell him was that I didn't want to continue with the mission. He suggested I increase my hover altitude to minimize the circulating dust that obscured visibility. I told him that an increase in hover altitude would make it more difficult for the flight mechanic to see the rescue swimmer and precisely place him on the cliff face. Without hearing from me that I didn't feel the mission could continue safely, the operations officer endorsed continuing the mission.

During the refueling evolution, we didn't take any time to debrief what had happened because we each perceived the need to get back out to Road's End as quickly as possible. No one felt good about continuing the mission, but no one spoke up. During the first rescue, the rescue swimmer had to physically grip the child as the child began to let go and both he and the survivor were dragged 10 feet up the cliff. After attaching to the survivor with the rescue strop, the hoist cable unknowingly wrapped around his leg, and he was pulled up the cliff with the survivor in an inverted position before snapping upright. We did not discuss this while on deck. It was clearly an internal communication breakdown in CRM.

This situation also illustrates the flight discipline and leadership tenets of CRM. Flight discipline and leadership require that crewmembers employ an aircraft within common sense guidelines in the presence of temptation to do otherwise. I equate common sense guidelines with knowing and respecting the limits of your crew and yourself. I was leading my crew beyond prudent limits because of our emotional commitment to saving the lives of children, but I didn't have the objectivity and presence of mind to say that we shouldn't finish the mission.

We departed Newport for Road's End and I established a hover in the same place that we had prior to conducting the first two hoists. I noticed that the wind direction appeared to have shifted easterly and that blowing debris was not moving aft of the aircraft. As soon as the flight mechanic

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reported the rescue swimmer had positive contact, dust began to completely obscure my view with the NVGs. I lost all visual cues, and told the flight mechanic to "get the swimmer up now!" An experienced pilot once told me that 80% torque and nose on the horizon during inadvertent IMC saved his bacon, and for some reason it was as if he was sitting next to me telling me just that. It felt like 10 or more seconds that I wasn't able to see the cliff or the rapidly rising headland 25 feet to my right. My copilot couldn't see the dead trees to his left, but I remember him once again blocking any left movement of the cyclic.

We emerged from the dust cloud with the headland inside of a rotor disk distance to my right and well-forward of our original position. The rescue swimmer had rocketed off the crest of the cliff and had come nearly eye-level with my copilot on a forward swing. The hoist cable then wrapped around the nose wheel with the rescue swimmer dangling helplessly below the aircraft. We managed to make a slow climbing left turn away from the headland to the right. Offshore rocks and crashing waves briefly got my attention through the chin bubble as I turned my attention from the instruments to attempt to acquire visual references under the NVGs. The flight mechanic came over the ICS and exclaimed that the "hoist cable was wrapped around the nose wheel, and that the swimmer would most likely need to be sheared off." I checked the RADALT, noted that we were climbing through 450' AWL, and shouted, "don't shear the swimmer!"

To compound the confusion and chaos, my copilot and I could not pick up any visual cues through the windscreen due to the lack of a visible horizon over the Pacific combined with excessive glare in the cockpit due to reflected cabin light off the dusty windscreen. Almost immediately after telling the flight mechanic not to shear, the rescue swimmer came over his handheld radio and excitedly asked, "Why are we so high?" He was seeing the lights of EMS below the cliff getting smaller and smaller and made several previous radio calls that were unintelligible due to static and rotor noise. I noticed my airspeed indicator was now fluttering between 10 and 20 knots and immediately realized I needed to increase airspeed and get down low over the surface in case the hoist cable parted and allowed the rescue swimmer to fall. We initiated a descent and the copilot came on the collective to help me arrest the aircraft's descent at 26' AWL. We air taxied at 50' AWL to the approach end of the runway at Pacific City, lowered down to a 10' hover, and the rescue swimmer released from the hoist hook and ran out of the rotor arc.

Situational awareness during this final stage of the flight saved our crew, but was also our downfall in making a poor decision to return to base after we had landed safely at Pacific City. Anyone who has been in a very tense scenario in the aircraft knows just how the chaos of the unexpected can wreak havoc with decision making and communication in an unusual situation. Crew communications were accurate, bold, and concise amidst distractions and hindrances to communication after the brown out. However, a crew must maintain situational awareness even after the aircraft has landed. We, as a crew, simply let our guard down and stopped assessing risk after the events that had transpired. We overlooked the possibility of aircraft damage and erroneously elected to fly the 30 NM back to Newport.

I challenge you to reexamine missions, such as night vertical surface rescues, that are so hazardous that we do not train for them. I also urge you to consider how you would foster Crew Resource Management and Operational Risk Management in a similar situation. How can you strengthen communication within your crew, with your command, and with other first responders during a case? When faced with tragic circumstances, such as children in peril, do you allow your emotions to cloud your professional judgment?

Important STACOM Information

DAC Charles W. Lent
Directorate of Evaluation and Standardization
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Fort Rucker, Ala

The Directorate of Evaluation and Standardization (DES) publishes standardization communications (STACOMs) in order to clarify standardization policy in accordance with AR 95-1. STACOMs may precede formal staffing and distribution of Department of the Army official policy. On a recurring basis, DES will review a listing of active STACOMS and publish it on the Army Knowledge Online (AKO) portal and in FlightFax.

Active STACOMS are available on the DES main page: https://www.us.army.mil/suite/page/337793 or DES homepage on AKO-S (SIPR) at http://www.us.army.smil.mil/suite/page/9746 A website link can be saved in your browser's favorites or bookmarks for direct access. Once logged into AKO and displaying the new DES homepage you can click “Add to Favorites” at the top right edge of the page.

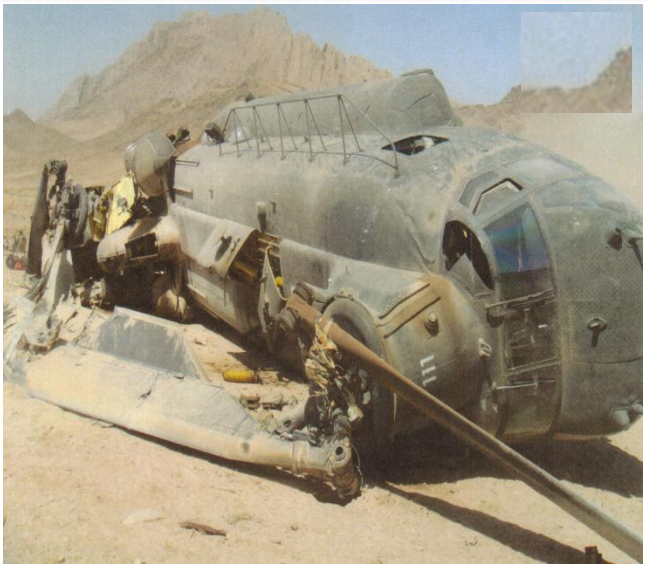
In an effort to ensure the field has the most current information, a review of all active STACOMS was recently conducted. Previously published STACOMS not listed in the table below have been and rescinded and are located in the “rescinded” folder on the AKO portal for historical purposes.

For questions or more information contact DAC Charles W. Lent at (334) 255-9098 or e-mail charles.w.lent.civ@mail.mil.

STACOM #	Date Published	Title
09-01	Apr 09	H60 ATP Guidance
09-03	Aug 09	CH47F ATP Guidance
10-01	Jan 10	LUH PPC and ATM Tasks
10-07	Aug 10	H-60M Series Transition
10-10	Sep 10	Clarification of FM 3-04.11
11-02	Aug 11	SUAS Master Trainer
12-01	Apr 12	UH72 SI FI Qualification Requirements
12-03	Dec 12	AH-64E Series Transition
13-01	Jan 13	CBRN Requirement
13-02	Mar 13	CH47 F Qualification Guidance
13-03	Apr 13	C-12 Torque Limitations
13-04	May 13	TC 3-04.21 (TC 1-272) FAD Clarification
13-05	Jul 13	OH-58D FADEC Training Guidance

Mishap Review: Multi-ship AASLT

While conducting a Day, multi-ship, air assault landing to an unimproved HLZ, the CH-47D encountered brown-out conditions. The aircraft touched down with a right roll resulting in the main rotor blades striking the ground. The aircraft came to rest on its right side with major damage and only minor injuries to the crew and passengers.



History of flight

The mission was a five ship (3 x UH; 2 x CH) trigger based air assault to action a preplanned objective. Crews reported for duty at 0200L completing pre-flights and aircraft prep. The air mission brief was conducted at 0300L followed by individual crew briefs. The mission risk was moderate with the task force commander as the final mission approval authority. The weather forecast was for clear conditions and unlimited visibility. Winds were 070/08; temp +37 and MSL landing altitude of 5100 feet.

The flight departed at 0450L en route to a staging area ten minutes away with the accident aircraft in the trail position. Upon arrival at the staging area the flight shut down, conducted an update brief, and remained on stand-by for the on-call mission. At 0800L the flight departed the staging area for the ten minute flight to the objective. Upon arrival, the two CH-47's held vicinity of the RP awaiting call-in to their designated LZ. At 0820L the two Ch-47Ds departed the RP for their LZ in a staggered right formation, 5 – 10 rotor disk separation with the accident aircraft in trail. The lead Chinook landed with moderate dust. The accident aircraft (trail) during approach entered the dust cloud created by the lead aircraft and continued in a landing profile. At approximately 5 to 10 feet the pilot on the controls lost visual contact with the ground. The aircraft touched down with a right roll followed by the main rotor blades contacting the ground. The aircraft came to rest on its right side with extensive damage and only minor injuries to the crew and passengers.

Crewmember experience

The PC, sitting in the left seat, had 630 hours total flight time, 550 in theCH-47D with 104 hours as a PC. The PI had nearly 2300 hours total time with 875 in the CH-47D and nearly 1000 hours PC time. The unit was in the process of RIP/TOA with the PC assigned to the departing unit and the PI assigned to the incoming unit.

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Commentary

The accident investigation determined that the crew failed to execute a go-around when visual contact with the intended landing area was lost. Additionally, the pilot not on the controls (PC) directed his attention inside the cockpit during a critical phase of landing. Also, during the landing sequence, the passengers removed their restraints prior to the completion of the landing without direction from a member of the crew. As a result, they suffered minor injuries when they were tossed about in the cargo area during the crash sequence. No passenger brief or static-load training had been completed.

Manned Aircraft Class A – C Mishap Table as of 25 Nov 13

	Month	FY 13					FY 14			
		Class A Mishaps	Class B Mishaps	Class C Mishaps	Fatalities		Class A Mishaps	Class B Mishaps	Class C Mishaps	Fatalities
1st Qtr	October	1	0	7	0			1	3	
	November	0	1	5	0		3		3	
	December	2	1	0	0					
2nd Qtr	January	0	0	6	0					
	February	0	0	2	0					
	March	2	1	5	6					
3rd Qtr	April	1	1	6	2					
	May	0	0	5	0					
	June	1	1	3	0					
4th Qtr	July	0	0	6	0					
	August	1	1	7	0					
	September	0	1	0	0					
	Total for Year	8	7	52	8	Year to Date	3	1	6	0

Mishap Review: MEDEVAC Chase

While conducting an NVG landing to an unimproved HLZ under zero illumination conditions, the HH-60L encountered brown-out conditions. While attempting a go-around, the aircraft drifted and impacted rising terrain coming to rest on its right side. A post crash fire destroyed the aircraft and two crewmembers sustained moderate injuries.

History of flight

The mission was a two-ship on-call support for MEDEVAC. The crews began their duty day at 0900L with pre-flights and aircraft run-ups. Weather, threat and ops briefs were completed with a moderate risk designated for the mission and approved by the task force commander. The weather was few clouds at 15,000 feet; visibility 6 miles with haze; winds 360/25 knots. Temperature was +22C and PA of +8200 feet. The illumination for the flight was 0%.

At 2030 the crew was notified of a potential MEDEVAC request at a remote site a significant distance from home base. The flight departed at 2100L with the accident aircraft performing duties as chase (Chalk 2). The flight arrived at a standby location at approximately 2230 to wait to be called forward.

Approximately an hour later the flight departed for the pickup site with 20 minutes en route and arrived just after midnight. The lead aircraft landed and began loading patients. The AMC in Chalk 1 determined Chalk 2 would also need to land at the site. Chalk 2 conducted a low approach and then set up to land to the right side of lead. During the VMC approach, at approximately a 10 foot hover, the aircraft became engulfed in a dust cloud. Decreasing rotor RPM was encountered when a go-around was attempted. With loss of visual references, the aircraft drifted forward, up, and to the right followed by the main rotor striking rising terrain. The aircraft crashed and came to rest on its right side. The crew was able to exit the aircraft before a post-crash fire developed and engulfed the airframe. The two pilots sustained minor injuries and the two crewmembers received moderate injuries.

Crewmember experience

The PC, sitting in the right seat, had more than 680 hours total flight time, with 600 in the UH-60 and 120 hours NVG time. The PI, flying in the left seat, had 270 hours total time, 190 hours in the UH-60 and 33 hours NVG time. The CE in the right crew chief seat had 1500 hours with 440 NVG. The MO, sitting in the left crew seat, had 44 total hours with 11 NVG.

Commentary

The accident board determined the PC on the flight controls, after loss of visual references, failed to correct for drift or adjust heading to avoid known obstacles. It was also noted the pilots were not utilizing the HUD, which might have assisted in maintaining orientation.

The top five 24 Mar 1982 Flightfax

In fiscal year 81, a total of 353 Class A, B, and C flight-related mishaps were recorded. An in-depth analysis was performed on 106 of these mishaps. The 106 mishaps analyzed accounted for 96 percent of the total number of flight-related fatalities last year, 94 percent of the destroyed aircraft, and 83 percent of the total dollar losses. This analysis identified the five top aviation mishap cause factors for FY 81 . The top five cause factors ranked in terms of frequency of occurrence, severity of injury, and dollar losses were:

1. Faulty judgment
2. Inexperience
3. Overconfidence in others
4. Improper motivation
5. Overconfidence in self

Faulty judgment

Most of the cases of faulty judgment involved violations of flight discipline at NOE or low-level attitudes. Generally, the violations were committed by properly trained and prepared aviators who disregarded or ignored regulations and directives. A typical example involved an OH-58A

IP who gave a pilot a forced landing while hovering over an unsuitable landing area ... a course of action he knew to be improper. The helicopter skids sank in the soft terrain and the aircraft came to rest on its side.

Inexperience

The mishaps involving inexperience were the result of errors committed by aircrew members whose skills in flying or maintaining the aircraft were not at the level required to do the job. In one case, an OH-58 pilot just out of flight school was assigned an NOE flight. He placed the aircraft in a steep left turn to evade a simulated engagement by an aggressor tank, and his main rotor blades hit a sand dune. The severity of the flight maneuver was not warranted by the existing conditions.

Overconfidence In others

Mishaps involving overconfidence in others were the result of tasks critical to flight safety not being accomplished due to a belief that another had performed or would perform the tasks. In some of the cases, IPs delayed taking corrective action for too long because they believed the pilot would correct his own mistakes. Following is a classic example. After a tachometer generator failure, a UH-1 IP took the controls from the rated student pilot and auto rotated into water with the engine still running. When the emergency occurred, the pilot was flying under the hood and the IP was looking outside the aircraft. When the pilot said something about an engine failure, the IP had such confidence in the pilot that he assumed the pilot had confirmed an engine failure, and he did not check his gas producer to determine the extent of the emergency.

Improper motivation

Mishaps involving improper motivation were caused by errors made due to an excessive desire on the part of the pilot to impress someone, to complete a mission, or simply to relieve boredom. In one case, a UH-1 H pilot, while awaiting IFR clearance, decided to perform a hydraulic check at

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operating rpm rather than at engine idle as required by the operators manual. He just got tired of sitting and waiting and decided to do "something." As a result, when the pilot put movement into the cyclic as required by the hydraulic check, the aircraft rolled over.

Overconfidence In self

A large number of mishaps were caused by aviators performing a prohibited or unauthorized action and violating established procedures. These aviators committed these acts with full confidence that they could handle any problem resulting from their undisciplined behavior. An OH-58 pilot had just completed a day tactical mission and was flying toward a landing point. Visibility was unlimited. The pilot had crossed a valley and was passing over higher terrain. Flying about 35 feet above the ground, the pilot saw some wires in front of him. He banked steeply to the left, but the aircraft hit three of the wires and crashed. The pilot had not done a hazards recon of the route he was flying. He knew he should not have been as low as he was, but he was confident in his ability to avoid hazards during periods of clear weather and unlimited visibility.

Crew error

In fiscal 81, Army aircraft mishaps killed 29 aircrew members and passengers, injured another 111 , destroyed 37 aircraft, and cost the Army almost $40 million. Through the first 5 months of this fiscal year, 18 flight-related Class A mishaps had been recorded. While investigations of all 18 mishaps are not complete at this writing, crew error has been identified as a definite factor in 11 of the 18. These 11 crew error mishaps resulted in 11 fatalities, 10 destroyed aircraft, and the loss of $9,309,629 in property damage and injury costs.

• During preflight, a pilot did not insure the engine cowling of his UH-1 was secure. The cowling came off during flight and hit the tail rotor. The pilot entered autorotation and hit the ground with enough force to destroy the aircraft. Result: a $619,000 loss.

• A PIC allowed his OH-58 to start across an active runway because he misinterpreted tower instructions to hold short of the runway. The copilot performed a quick stop maneuver to try to stop short of the runway. The main rotor struck and severed the tail boom, and the helicopter landed hard. Result: $143,782 in damages.

• An OV-1 pilot exceeded ATM bank standards while trying to avoid further penetration of restricted airspace he had entered. He put the aircraft in a bank of approximately 90 degrees and allowed the Mohawk to assume a nose-low attitude. Result: 2 fatalities and a $2,892,634 loss.

• The pilot of an OH-58 did not adequately secure his flight jacket. The jacket blew out of the helicopter and hit the tail rotor, causing the loss of both tail rotor blades and gearbox. The pilot autorotated into trees. Result: $143,782 in damages.

• An AH-1 S pilot's night vision goggles failed while the aircraft was flying at 100 knots and 100 feet above trees. The crew did not adequately coordinate exchange of control from pilot to copilot, and the Cobra crashed into trees and burned. Result: a $1,598,131 loss.

• When a UH-1H vibrated excessively during flight, the pilot began looking for a landing spot. He used too much airspeed during the approach and overshot the intended landing point. The Huey descended into trees, landed hard, and was destroyed. Result: a $618,055 loss.

• During takeoff, the pilots of two OH-58s allowed their helicopters to drift into each other. Result: 4 fatalities and $345,680 in damages.

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• A Cobra pilot was taking off from a tactical field location and allowed his helicopter to drift backward into trees. Result: $650,000 in damages.

• A UH-1H pilot allowed his helicopter to roll on its right side (dynamic rollover) during takeoff from a field site. Result: $618,055 in damages.

• The pilot of an OH-6 flew his aircraft into wires. Result: 1 fatality and $140,450 in damages.

• When the pilot of a UH-1 tried to hover between parked aircraft on the ramp, his main rotor blade hit the tied down rotor blade of a parked aircraft. Result: $200,000 in damages.

The situation is not improving. As this issue goes to press, three more Class A mishaps have been recorded. Preliminary information indicates that crew error may be a factor in all of these. There's nothing new nor unique about the cause of these crew error mishaps. They happened because commanders, supervisors, SIPs, IPs, PICs, and aviators allowed old "repeat" causes to creep back-unrecognized- into the aviation system. There's also nothing new nor unique about what's needed as a cure for the crew error problem. It's the elimination of substandard performance in every phase of operation by commanders, supervisors, SIPs, IPs, PICs, and aviators.

And the time to begin is now.

UAS Class A – C Mishap Table as of 25 Nov 13

	FY 13 UAS Mishaps					FY 14 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	0	6	W/GE	1			1
MQ-5	2	0	3	5	Hunter	1			1
RQ-7	0	4	10	14	Shadow		4	1	5
RQ-11					Raven				
RQ-20	0	0	6	6	Puma				
YMQ-18									
SUAV					SUAV				
Aerostat	1	3	1	5	Aerostat	1			1
Total for Year	8	8	20	36	Year to Date	3	4	1	8

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Selected Aircraft Mishap Briefs

Information based on Preliminary reports of aircraft mishaps reported in October 2013.

Observation helicopters

OH-58D 

-Aircraft main rotor blade made contact with the tail boom during termination phase of a demonstrated autorotation. Damage reported to MRB and T/R drive shaft, coupling, and cover.(Class C)

Utility helicopters

UH-60- 

-M Series. Aircraft landed hard on approach to an unimproved LZ in dust conditions and sustained airframe damage to the undercarriage, reportedly from obstacles on the LZ. (Class B)

-M Series. Three of four anti-flap MR brackets apparently separated in flight and the 4th was still present but cracked. Damage was also identified to the 'red' and 'blue' blade of the main rotor system and is presumed to have been due to contact with the flaps as they separated. (Class C)

Unmanned Aircraft Systems

MQ-1C 

Controller lost link with the system as it was descending to land on the runway and it crashed resulting in Class A damage. (Class A)

RQ-7B 

-Contract crew experienced Ignition and GEN FAIL displays as system was on climb-out to mission altitude. Crew was able to glide the system to a recoverable location and initiated FTS but the system contacted the ground prior to full chute-deployment. (Class B)

-System generated an un-commanded RPM spike and upward pitch during landing under the TALS, after which engine-failure was reported. System descended to ground impact on the runway. (Class C)

Learn from the mistakes of others -
You won't live long enough to make them all yourself.

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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