Number 34 February 2014

Flightfax®

Online newsletter of Army aircraft mishap prevention information

The accident numbers for the first quarter of FY14 are in, and the news is not good. So far in this FY, we have experienced 8 Class As, 1 Class B, and 12 Class C accidents, compared to FY 13 with 3 Class A, 2 Class B, and 17 Class C and to FY12 with 8 Class A, 6 Class B, and 43 Class C. These statistics present an even more challenging reality given that our flying hour programs show that we are flying about 20% fewer flight hours than the previous three years. While one can objectively measure the number of past accidents along with flight hours to come up with accident rates, it is a bit more difficult to use OPTEMPO numbers as a predictor of the future. There are several factors that influence safe aviation operations as our flying hour program decreases. None of these can be statistically proven by data analysis, but they are known to commanders and experienced aviators that have lived through the reduced flight hours of the 1990s.

First and in the aggregate, accident rates tend to decrease as flight hours decrease. This seems counter-intuitive, but I believe it is a measure of exposure to risk. When an organization has fewer flight hours we tend to focus on the basic tasks of RL progressions, NVG currency, and continuation training, and not conducting the larger combined arms training events. When the majority of our flight hours are spent on lower risk crew level training, the risk we take is reduced but our overall proficiency in complex tasks is also less.

Second, accident rates tend to increase when organizations transition from steady state training into a deployment or contingency operation. As with any transition, we are asked to execute more complex operations, and then we add in the pressure of mission success for our air mission commanders and pilots in command. These factors, coupled with different terrain and threat from the enemy, significantly increases our exposure to risk. For example, this type of spike in accident rates (number of Class A accidents per 100K flight hours) was very evident in the beginning phases of both OEF and OIF with an almost 300% increase as we transitioned into a combat focused aviation force. In FY00 our Class A accident rate was 0.62 and in FY01 the rate was 1.08, which almost tripled to 2.67 in FY01 and 2.74 in FY02.

Which leads to my last point and the good news. The single most influential force in reducing aviation accidents is leadership. Engaged leaders at all echelons, air mission commanders, and pilots in command were able to drive down the accident rates once they gained situational understanding of their environment through sound operational planning, not accepting any unnecessary risk, and clear command guidance to their subordinates to guide their decision making. The accident statistics reveal that, despite increasing deployed OPTEMPO, the accident rates were decreasing. Through leadership, we went from 26 Class A accidents in FY02 while flying approximately 970K hours down to 14 Class A

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accidents in FY 11 with over 1.27 million flight hours. The numbers don't lie, leadership works.

So the question that I will ask is, are you ready for your next transition? Do you understand impact of reduced flight hours on your own proficiency, and that of those in your unit? Have we established the right command climate and emplaced the right control measures within our organizations that balance risk against mission requirements? What are you personally going to do to maximize the training value of every flight hour to ensure we are as ready as possible for the next contingency mission? Lastly, are you prepared to have the honest conversation with your commander to truly convey the levels of risk we are accepting and your crews proficiency levels in meeting those mission tasks?

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

LTC Mike Higginbotham
Aviation Director, Future Operations
US Army Combat Readiness/Safety Center
email: michael.d.higginbotham.mil@mail.mil

Manned Aircraft Class A – C Mishap Table as of 25 Feb 14

	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		0	1	2	0
	November	0	1	5	0		3	0	5	0
	December	2	1	0	0		1	0	3	0
2nd Qtr	January	0	0	6	0		3	0	2	3
	February	0	0	2	0		1	0	0	0
	March	2	1	5	6					
3rd Qtr	April	1	1	6	2					
	May	0	0	6	0					
	June	1	1	4	0					
4th Qtr	July	0	0	7	0					
	August	1	1	9	0					
	September	0	1	1	0					
	Total for Year	8	7	58	8	Year to Date	8	1	12	3

My Memorable Flight:
Reap the Benefits of Your Training

CHIEF WARRANT OFFICER 3 BRIAN SPOTTS
Standardization Instructor Pilot
Flatiron, 1-223rd Aviation Regiment
Fort Rucker, Ala.

When I was a 2,000-hour CH-47D Chinook instructor pilot in a heavy lift unit deployed to Bagram Army Airfield (BAAF), Afghanistan, my crew was tasked to conduct a six ship night vision goggle (NVG) air assault in support of Operation Enduring Freedom. In addition, I was providing a local area orientation and air assault familiarization flight for a "torch party" commander who would assume operations in FOB Sharana, Afghanistan.

Our mission was to depart BAAF and pick up troops at a neighboring airbase for insertion 60 miles to the south. We were an "ideal" crew for the mission: I was a flight lead instructor pilot and my copilot was a skilled pilot-in-command with 1,200 hours. Just minutes before departure we completed our mission briefing, battle rehearsal, and weather update. The weather forecast was beautiful, sky clear with unrestricted visibility.

To mitigate risk, we elected to depart as three serials, two CH-47Ds, two UH-60Ls, and two AH-64Ds with five minutes of separation between each flight. About 15 minutes after departure, we could see lightning strikes in the distance. However, because of the light intensification capabilities of the NVGs, we were unable to determine the exact location of the strikes. We promptly passed a PIREP for lightning near the proposed LZ and an overcast ceiling to the battalion commander who was the air mission commander (AMC) positioned in the second UH-60L.

We informed him we would like to continue along the route and update weather upon arrival to determine mission impacts on the air assault. This was the first opportunity to break the chain of the near catastrophic events that would follow. We were still in a position to pause, contact our weather forecasting agency, address the unforecast lightning and make an informed decision before continuing. In fact, our third serial had not even departed BAAF.

We were flying at 1,000 AGL and nearly 10,000 MSL in a three mile wide valley with mountaintops that surpassed 15,000 MSL. As we continued along the route, the lightning activity intensified and each strike seemed closer than the last. However, it appeared to be south of our objective and flight visibility remained unrestricted. We began to fly underneath an overcast layer of clouds with light rain and reduced visibility (approximately five statute miles). With each lightning strike, I started to question our ability to complete the mission. We quickly realized the lightning was much closer than we estimated and we were flying directly into a heavy rain storm.

I passed information to the AMC that the lightning and distant rain seemed to obstruct our flight path to the forward operating base where we would be picking up our troops. I made the recommendation to abort the mission, return to Bagram, and reevaluate the weather.

Unfortunately, it was too late! As we began a slow turn back to BAAF, the overcast clouds began to produce heavy rain. As we continued our turn, visibility dropped from five miles, to three miles, to a half mile in a matter of seconds. About midway through the turn I believed the aircraft had been struck by lightning (our countermeasure system had in fact launched a volley of inadvertent flares), all visual reference with the ground was lost and I couldn't see past the windscreen. Our uneventful flight had turned into an emergency! I announced "inadvertent IMC right seat," began

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a turn to my last heading and immediately initiated a 1,500 fpm rate of climb. My copilot and crewmembers followed suit and announced “inadvertent IMC.”

Chalk 2 began a steep descent, maintaining visual references with a single light on the ground. I announced to the AMC I was inadvertent IMC and had initiated a climb. I instructed my copilot we were going to climb to 12,000 MSL and begin a turn back to Bagram. This would provide obstruction clearance in our immediate vicinity, but we would need to climb higher as we continued north towards Bagram. At 12,000 MSL I began a standard rate turn to the north, and announced I would continue my climb to 13,000 MSL while we worked our exact position.

Every mile counted, if we were off course by as little as a mile, it would be the difference between life and death. We had flown much of the year with electronic kneeboards (EDM) and had augmented our situational awareness with commercial off-the-shelf GPS receivers with terrain banding. However, with the lightning activity in the area, the GPS receiver signal was interrupted and failed. I had relied so heavily on the GPS for terrain avoidance I failed to utilize the EDM held by the pilot in the troop commander seat for situational awareness.

As we passed through 13,000 MSL we contacted Bagram approach control, declared an emergency and requested radar vectors for the ILS approach. The controller informed us we were outside of the radar coverage area and suggested we contact Kabul approach control. However, Kabul approach control was difficult to understand given the strong language barrier. We reiterated we were declaring an emergency and requested radar vectors from our position to intercept the localizer and complete the ILS approach into Bagram. The controller stated in broken English, “Say again, over.” Ultimately, radar services were never established and we continued our climb to 14,000 MSL and attempted to determine our exact location.

Throughout the climb we performed the task precisely to the standards prescribed in the CH-47D aircrew training manual. I announced and selected the heading select mode and positioned the cursor for a twenty degree right-hand turn in an effort to turn towards the smallest ridgeline within the valley. In a steady climb, overwhelmed and task saturated, I focused my attention away from the attitude indicator. My copilot, exactly as instructed, announced “the wings are not level.” Indeed, the attitude indicator showed a standard rate turn to the right and I applied cyclic to level the wings.

I began to feel hypoxic with the high altitude and announced it to my copilot. As we passed through 14,000 MSL my copilot stated “14,000, what altitude are you going to level off at?” Simultaneously, several radios transmitted. I could hear the AMC announce that the flight would posture on Alpha ramp, contact the pilot to metro service and readdress weather for the assault. At this point I became extremely frustrated and angry, a clear symptom I was becoming hypoxic. Regretfully, I snarled on the radio we were in an emergency, we did not know our exact position, and he needed to stop talking over the radio. I knew my harsh tone was a mistake, but I was in self preservation mode and I clearly had my hands full.

I was still task saturated and overwhelmed when my copilot announced “the wings are not level.” The attitude indicator again showed a standard rate turn to the right and I applied cyclic to level the wings. Frustrated, I turned off the heading select feature, leveled the wings and announced my intent to climb to 15,000 MSL. I made a judgment call, balancing a safe altitude to recover back to Bagram and prolonged hypoxia. At 14,700 MSL we climbed out of the massive storm and above the highest terrain. To my disbelief, Chalk 2 was exactly 10,000 feet directly below us. We had flown the centerline of the valley for nearly seven miles. We contacted Bagram

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approach, now within range, and maintained positive radar control as we descended towards Chalk 2. The weather over Bagram matched the forecast, sky clear with unrestricted visibility.

My crew and I walked away from an undamaged aircraft after a memorable flight. We survived this emergency because of the training emphasis we placed on inadvertent IMC procedures. Fortunately, my crew correctly responded to the emergency and I am not writing about an unusual attitude recovery procedure. I am thankful we were able to reap the benefits of our training and prevent a catastrophic loss. I have and will continue to stress the importance of breaking the accident chain and training inadvertent IMC in realistic scenarios. Emphasis that was drilled time and time again by a previous instructor and mentor who placed great emphasis and intensity on training inadvertent IMC.

CW3 Spotts is the Standardization Instructor Pilot of FLATIRON, 1-223rd AVN REGT, Fort Rucker, Ala. He may be contacted at brian.j.spotts@us.army.mil.

UAS Class A – C Mishap Table as of 25 Feb14

	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	2	1	1	4
MQ-5	2	0	3	5	Hunter	1			1
RQ-7	0	4	10	14	Shadow		5	1	6
RQ-11					Raven			1	1
RQ-20	0	0	6	6	Puma			1	1
YMQ-18									
SUAV					SUAV				
Aerostat	2	3	1	6	Aerostat	1			1
Total for Year	9	8	20	37	Year to Date	4	6	4	14

Two things are needed to prevent wire strikes – Brains and Altitude. If you are low on one, you'd better have more of the other…

Aviation Basic Knowledge

Chief Warrant Officer 5 Paul F. Druse
Directorate of Evaluation and Standardization
U.S. Army Aviation Center of Excellence
Fort Rucker, Ala
Chief of Standards

*(**ba·sic**: Adjective \ˈbā-sik also -zik\ : forming or relating to the most important part of something.)*

Over the past year I have had the pleasure of traveling with DES and seeing the finest aviation units in the world. We have changed greatly in the last 12 years as a result of fighting two wars. Our pilots have arguably flown more and had the opportunity to experience more than I did in my first 12 years of Army aviation service. Unfortunately, a trend we at DES are seeing during our unit visits is a decrease in our basic aviation knowledge.

For those who have not experienced a DES visit recently, we issue a 50 question written examination during the unit assessment. Our goal is a 100% evaluation (written, oral, or flight) of all available crewmembers assigned to the Aircrew Training Program (ATP). Ideally, the written test is the easiest way to evaluate a majority of the unit. The written exams are broken into subject areas such as: aircraft specific, instruments, Standing Operating Procedure (SOP) and emergency procedures/limitations. Statistically, instruments, EPs/limitations, and Standing Operating Procedure (SOP) are among the weakest subject areas.

If I had to pick a group that is most vulnerable to fail the exam, it would be the RL1 non-tracked pilot in command (PC), Warrant or Commissioned. These individuals are generally mission focused and not taking the time to ensure their basic knowledge is maintained. These individuals are flying most of the unit's missions and usually have an additional duty or leadership position that tends to deflect their attention. They are no longer in the crosshairs of instructor pilots since the latter are busy with progressions or conducting APART evaluations.

Arguably, the group identified above (non-tracked PCs) will have more of an influence on your newly progressed aviator or crewmember than any other individual. These individuals essentially become your primary day-to-day trainer for the aspiring PC's. They must continue to train and challenge less experienced aviators on aviation basic knowledge subjects found in the ATM in order to maintain a fundamentally sound unit.

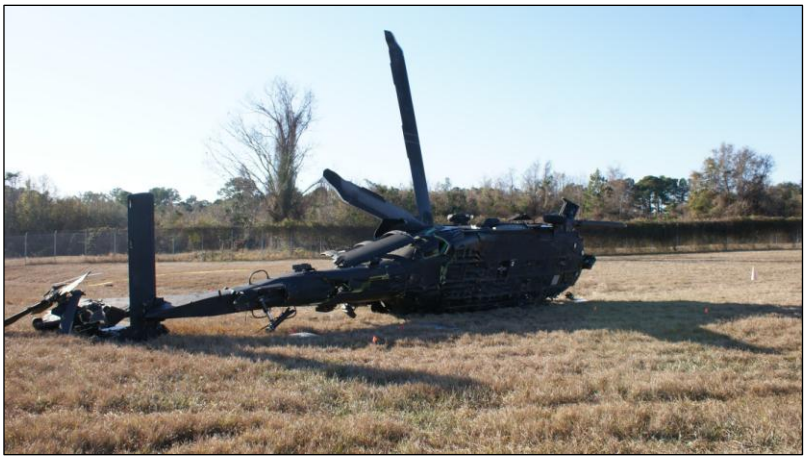
Instructors, I challenge you to not lose sight of the unit no-notice and academic training programs. These two programs have an immediate effect on the overall depth of knowledge within your organization. Do not become fixated with progression and APART evaluations, as this is but a small part of your job. Challenge your aviators to conduct classes and lead discussions as a way for them to develop.

Ultimately, all aviators are responsible for maintaining basic aviation knowledge of subjects found in the ATM. As the definition states: "basic" knowledge is "the most important part of something" and that is our aviation knowledge. Our aviation knowledge is the foundation that we all use as we integrate into different positions throughout our careers in Army aviation. In order to be true professionals we must all be responsible and stay in the books.

--CW5 Paul Druse, DES Chief of Standardization, may be contacted at (334) 255-1582, DSN 558.

Mishap Review: Loss of Tail Rotor Control

During the conduct of a NVG VMC approach to the runway, at approximately 80 feet AGL, the H-60M began an un-arrested right yaw. The aircraft rotated several times before impacting the ground. One crewmember was killed and two crewmembers received serious injuries.



History of flight

The mission was single-ship day, night and NVG continuation training for the crew. The risk assessment worksheet and mission brief were completed the day prior with the initial and residual risk being low. The crew show time was 1300L with the pre-flight being performed at 1330L. At 1500L the crew conducted their mission brief at the aircraft . The weather was scattered clouds at 5,500 feet, broken layer (ceiling) at 10,000 feet. Visibility was unrestricted. Winds were out of the northwest at 9 knots with gusts up to 20 knots. The moon was full with no significant weather phenomenon reported in the local area.

The aircraft departed at 1527L en route to a distant airfield destination with practice approaches along the way. The aircraft arrived at its destination airfield at 1830L and shutdown. Following dinner, the crew departed on their return flight home under NVGs at 2039L.

At 2300L the crew reported to the tower they were inbound for landing. The tower cleared them for entry with airfield traffic landing to the west. Turning base, the tower cleared the aircraft for the option. While the crew conducted the VMC approach to the runway, at an AGL altitude of approximately 80 feet, the aircraft began to yaw/spin to the right with full left pedal applied. The aircraft completed several rotations before the PCLs were pulled off. With high G forces the aircraft impacted nearly upright with approximately 10 degrees left wheel low and 10 degrees nose up attitude. At impact, the aircraft rolled onto the left side of the airframe where it came to rest. The PI sustained fatal injuries with the PC and CE being seriously injured.

Crewmember experience

The PC, sitting in the left seat, had more than 2,160 hours total flight time, 773 as a PC, with 2,000 hours in the UH-60 (300 H-60M) and 890 hours NVG time. He had 800 hours of combat time. The PI, flying in the right seat, had over 1,200 hours total time, nearly 300 as a PC, with 1,100 hours in the UH-60 (180 H-60M) and 300 hours NVG time. His combat

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time was 677 hours. The CE, located in the right crewchief seat, had a total of 289 hours with 13 NVG.

Commentary

The accident investigation determined that the tail rotor pitch change shaft failed. This failure separated the linkage of the tail rotor pitch change shaft and the tail rotor servo, allowing the tail rotor to seek a neutral pitch and to be unresponsive to pilot flight control inputs. This caused the aircraft to enter an uncontrollable yaw with increasing rate.

SAFETY OF FLIGHT (SOF), H-60-14-SOF-02 requiring a one-time visual inspection of the Pitch Change Shaft Assembly (Servo Coupling Assembly) for proper installation of a cotter pin on the "Spanner Nut" on the outside of the Shaft Housing.

Shipboard operations involving wave action/swells

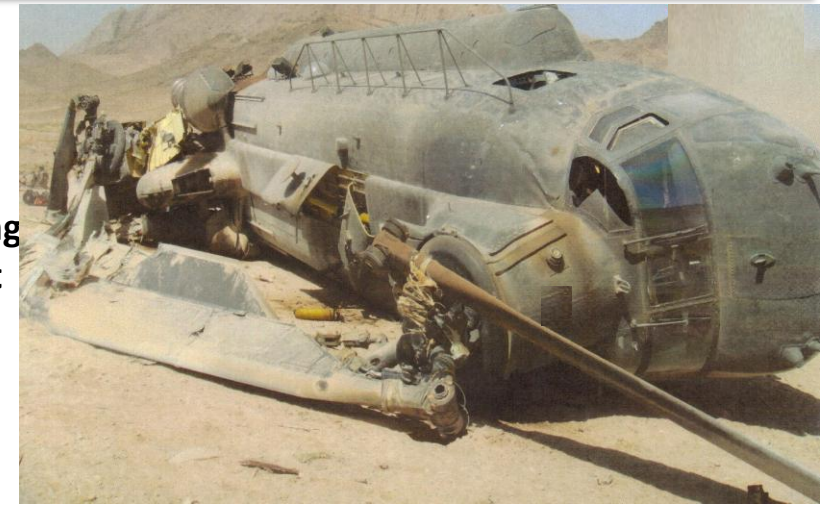
A Navy rotary wing aircraft was conducting passenger and cargo transfers between ships in the Carrier Strike Group. Upon completion of its replenishment mission, the helo maneuvered to recover to its assigned destroyer. The ship maneuvered to the southeast to achieve wind, pitch, and roll limits for the recovering aircraft. Winds were out of the northwest at 25 – 30 knots with seas at 5-7 feet. As the aircraft made its approach the officer of the Deck directed a wave-off when relative winds fluctuated outside of the green deck parameters. The ship's speed was increased to flank to attain a green deck. The aircraft made a safe approach and landed on the centerline with the main landing gear inside the wheel boxes. The aircraft was safely chocked and chained and a red deck was set. After setting the red deck, the ship's course was changed to the south, southeast while still at flank speed. During the turn the ship rolled 12 degrees to starboard followed by a 13 degrees to port and then a 16 degree roll back to starboard. When the destroyer rolled hard to starboard, a large wall of water came up and over the starboard side of the flight deck, exceeded the height of the aircraft rotor system and engulfed the still running aircraft. Immediately after water impact, the aircraft began breaking apart, shaking violently, and hopping/bouncing on the flight deck. The aircraft experienced multiple airframe failures, including separation of the main rotor blades, the tail cone, the left MLG and the tail rotor gearbox. The aircraft then slid off the left side of the flight deck into the water resulting in the loss of the two pilots.

Lessons learned

Both the ship and aviation communities lacked awareness about documented hazards presented by wave intrusion of the flight decks of destroyers. Past reports of similar, but less catastrophic incidents had been documented on other ships for several years. The lower flight decks combined with other factors, such as ship speed, relative seas, and sea state can create the potential for a high risk aviation environment not involving actual flight. With Army aircraft increasingly becoming involved with operating off of ships, it is important that aircrews and shipboard counterparts coordinate actions to raise awareness and mitigate the risk of this hazard. For additional information contact the Naval Safety Center at http://safetycenter.navy.mil/

Mishap Review: CH-47D Air Assault

During the conduct of a day, multi-aircraft landing, the CH-47D drifted right after contacting the ground, followed by the aircraft rolling onto its right side. Significant damage to the aircraft was incurred with minor injuries to the crew.



History of flight

The mission was a multi-ship, day, insertion of troops into unimproved HLZs. The flight consisted of three UH-60s and two CH-47s. The crews began their duty day at 0200L with an air mission brief at 0300L. The brief called for repositioning the flight to the PZ and stand-by for a trigger based air assault to a preplanned objective. After the AMB, the crews went to the aircraft and conducted crew briefs. The weather was clear conditions with unlimited visibility.

The aircraft departed home plate at 0450L with an arrival at the PZ of 0458L where the aircraft were shutdown to await the on-call departure. At 0715L and update brief was given, followed by aircraft run-ups. The flight departed the PZ at 0804L and arrived at the objective six minutes later. The two CH-47s held at the RP while the UH-60s proceeded to the objective. At 0820L, the CH-47s, with the accident aircraft in trail position, proceeded to the HLZ in stag right formation with 5 – 10 rotor disk separation. The lead CH-47 landed in moderate dust, creating a dust cloud. Chalk 2 reached the dust cloud and continued in a landing profile. Following touchdown of the aft wheels, and as the forward wheels came down, the aircraft began a rolling motion resulting in the aircraft impacting the ground on its right side. The aircraft sustained major damage with minor injuries to the occupants.

Crewmember experience

The PC, sitting in the left seat, had more than 630 hours total flight time, 100 as a PC, with 550 hours in the CH-47D. He had 385 hours of combat time. The PI, flying in the right seat, had nearly 2,300 hours total time, 986 as a PC, with 876 hours in the CH-47D and 528 hours combat time.

Commentary

The accident investigation determined that the crew failed to maintain visual orientation and to execute a go-around when visual contact with the intended point of landing was lost. Additionally, passengers removed their restraints in anticipation of exiting the aircraft prior to completion of the landing.

Creatures of the Night – Tricking the aviator's body into night alertness

April 2002 Flightfax

The issue of working reverse cycle in aviation is a complicated one. While aviators may be restricted by crew rest guidelines in how many hours they may fly, there is no restriction on *when* these hours may be flown. Many times aviators and other air crewmembers are required to fly or work at various times in the 24-hour day where they may need to reverse their work hours from typical duty day times to nights, early mornings, or late evenings. When this rotation occurs, aviators and crew members become "shift workers," in that they no longer work set hours, and may change their work hours every week, every 2-3 days, or possibly even on a daily basis, whether for the short-term or the long-term. When this happens, all the physiological symptoms typically experienced in shift work occur -- fatigue, sleepiness, insomnia, moodiness, etc. Along with these symptoms come performance problems and mistakes that can have disastrous consequences when flying.

The feelings of fatigue that people have when they rearrange their schedule (trying to stay awake at night and then sleeping during the day) are not unique. Almost everyone who works varying schedules feels sleepy or tired during the night, when they need to be alert and working. In addition, they experience difficulty sleeping during the day, when trying to recoup from a night of work. This is a normal feeling because night activity and day sleep are in opposition to the body's natural programming, or circadian rhythm.

The rhythms of wake and sleep, hormonal secretions, performance, and core body temperature, rise and fall in predictable patterns over the 24-hour day. As the day begins, body temperature, alertness, and performance are rising. This continues into the day, with a slight dip in the mid-afternoon, and then begins to fall as the day ends and night begins. In contrast, sleepiness declines as the day begins, has a small increase in the mid-afternoon, and then steadily increases as the day ends and night begins. The ability to go to sleep and stay asleep becomes increasingly difficult as the day progresses. One can readily determine why it is so difficult for shift workers to remain awake while on night shift, and sleep during daylight hours.

A host of activities—work, safety, health, family and social life—are affected when an individual experiences a constant change in schedules. So, what can the aviator or crewmember who works shifts do to make life easier and minimize feelings of irritability and tiredness? These suggestions can help:

+ Avoid caffeine 4-6 hours before bedtime.

+ Avoid sunlight after a night shift by wearing dark sunglasses while driving home.

Continued on next page

+ Stay indoors and avoid sunlight as much as possible until your sleep period is complete.

+ Relax before sleep time. Avoid stimulating activities, such as house and yard work.

+ Avoid alcohol for at least 3 hours before bedtime.

+ Avoid strenuous exercise at least 3 hours before bedtime.

+ Get a minimum of six hours of sleep; take naps if you cannot get enough sleep at one time.

The above strategies are very good at promoting sleep. However, other strategies may be needed to stay asleep.

- Sleep in your regular bedclothes and in your usual bed.
- Have a comfortable mattress and pillow.
- Make the bedroom cool and very dark.
- Remove the phone from the room and discourage daytime visitors.
- Disconnect the doorbell and hang a sign indicating a shift worker is sleeping.
- Use earplugs and a masking noise like a fan to cover outside distractions.
- Develop a sleep schedule.
- Communicate with family and friends your need to sleep and your sleep schedule.

Although sleeping as well as possible during the day is a great start to being alert during the night, sleepiness at night will continue to occur. One cannot completely trick the body into being alert during the night, because there is a strong physiological drive for sleep at night. The human body can adapt somewhat to staying awake all night, but it takes many days of strict schedules before it adjusts, and most shift workers are off the night shift by the time this occurs. However, there are some strategies that can improve alertness at night.

+ Use caffeine carefully; wait until you need a boost.

+ Eat low carbohydrate, low fat, high protein foods.

+ Use social interactions and physical activity/postural changes to help stimulate your environment.

+ Stay cooler than usual.

+ Prepare in advance for changes in sleep schedules by gradually adjusting your sleep time.

+ Use naps to obtain as much sleep as possible before the night's work begins.

It's important to be aware that adjusting to rotating schedules and reverse cycle is not easy. However, taking care of some of the manageable variables will lead to improved safety on the ground and in the air, better work performance, better relationships with family and friends, and better general health.

—Dr. Lynn Caldwell, USAARL J. Lynn Caldwell, Ph.D. U.S. Army Aeromedical Research Laboratory Fort Rucker, Ala

Selected Aircraft Mishap Briefs

Information based on Preliminary reports of aircraft mishaps reported in January 2014.

Observation helicopters

OH-58D 

-Aircraft experienced an NP exceedance (124%/10 sec) during run-up/FADEC system check. (Class C)

Utility helicopters

HH-60 

-L series. Aircraft was being ground-taxied for parking when it made contact with the wing of a parked privately owned plane. Aircraft was shut down w/o further incident. (Class A)

MH-60 

-M series. Crew was conducting routine ATM training in the traffic pattern when the aircraft impacted the ground. One crewmember sustained fatal injuries in the crash and the remaining crew (pilot and CE) sustained survivable injuries. (Class A)

Attack helicopters

AH-64D 

-Crew experienced a bird strike during RL Progression check ride. Aircraft left wing store sustained damage, requiring replacement.(Class C)

Fixed Wing

KA300 

-Aircraft was on base leg approach when approach tower personnel lost radio contact with the crew and observed smoke and flames emanating from the aircraft. Aircraft crashed approx. 1.8nm from the runway. Three fatalities. (Class A)

Unmanned Aircraft Systems

MQ-1C 

-System touched down hard during TALS approach to the runway. Damage: Internal structural damage and to the brake area and possibly payload bracket assembly. (Class C)

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