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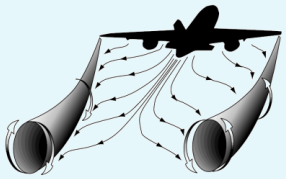

Online newsletter of Army aircraft mishap prevention information

Fiscal Year 14 continues to be a difficult year for Army Aviation. This year through the end of March, we have already exceeded the total number of Class A mishaps during all of FY13. By all objective measures, this year should have been better - reduced OPTEMPO, significant residual aircrew experience from those aviators that have deployed, and leaders that are focused on safe operations. Yet, something is different. The single most influential force in reducing aviation accidents is leadership. It is leadership within the command to promote and sustain the culture within their organizations that makes safety an imperative to readiness, and it is leadership inside the aircraft with pilots in command that have the moral courage to make the right decisions when faced with difficult choices or complex situations. In one of the mishaps investigated by CRC this year, it was openly recognized within the organization that the unit was an "accident waiting to happen" because of the high OPTEMPO and low state of proficiency of the crews. So the question is, are we as leaders doing everything possible to turn around the trend of FY14 and keep our accident rates as low as possible?

One of the chain of command's most effective tools in managing aviation risk is proper crew selection. A thorough understanding of a pilot's skill on the controls, knowledge of administrative and tactical SOPs and doctrine, and recency in the various mission tasks within the unit will allow leaders to properly assign them to the upcoming mission schedule. It is very easy to select the best aviators within the unit, but have we also identified those who should be paired with the best aviators for increased development?"
Somebody in your unit already knows which aviator will have the next accident. For as long as aviation has been aviation, there have been those pilots that enjoy pushing the limits, demonstrate questionable judgment, or put forth minimal effort to sustain their skills. In many of CRC's centralized accident investigations, the unit interviews contain the predictable statements of "I just knew he would be the next one to have an accident…." Aviators who fly without regard to regulations or who place others at risk due to their apathy are not a new problem. This month's Blast From the Past, titled "The Best Pilot In the Squadron", from the July 1980 edition of *Flightfax*, clearly articulates this concern was on leader's minds even 30 years ago. To stick with this theme, we have also included a DES STACOM dated 28 Feb 1979 that expands upon this concept.

It is good aviation leadership that properly assigns quality aircrews to complete the unit's assigned mission. It is great aviation leadership that actively seeks to identify those aircrew members that take unnecessary risk, demonstrate poor judgment, or are not sufficiently trained for the task. Once identified, these leaders will correct undisciplined behavior through remediation, or will provide the necessary training to ensure our aircrews can survive the unforgiving aviation environment. The other face of great aviation leadership is the individual moral courage of aircrew members to speak up when circumstances align against them. The chain of command needs to know when crew selection is not sufficient for the task, when aircrew are not proficient or prepared for their assigned task, or if individuals don't have the judgment or responsibility to execute their flight in accordance with standards. If you are an aircrew member, rated or non-rated, don't be afraid to speak up…..because your life is literally on the line.

Thank you for your incredible dedication to the Aviation Enterprise and to our customers, the troops on the ground. Until next month, fly safe and manage your risk levels!

LTC Mike Higginbotham
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FORSCOM Aviation Resource Management Survey (ARMS) Safety Program Management Trends Analysis Summary

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Each year, FORSCOM performs ARMS on hundreds of different organizations ranging from small detachments to battalion sized organizations and aviation support facilities. ARMS Trends for each functional area are posted on the ARMS web portal (https://www.us.army.mil/suite/page/962726) at the end of the fiscal year. The discussion presented here focuses on the trends for the functional area of Safety Management.

The major deficiencies identified during ARMS of safety management programs have been consistently the same for past years, but are identified as failing at a lower percentage. Those deficiencies are: untrained or inexperienced program mangers, inadequately written procedures specifying how the program objectives are met in the organization, inconsistent or incomplete historical documentation, and finally command and management failures to emphasize or establish programs to meet safety management and risk mitigating requirements.

Turnover of personnel and the continuous deployment, redeployment cycles complicate the training process of newly assigned aviation safety officers (ASO)/safety managers. Poorly written procedures (SOP) and no overlap (hand off) for program management further reduces the effective transition between program managers. The first critical step in reducing this deficiency is to ensure new program managers have received the training necessary to manage their program. One cannot expect an individual to manage a program and effectively accomplish program objectives without the appropriate training. The next step is to ensure step by step procedures (tasks) to accomplish program requirements are clearly established in writing. Establish a files management system for the program to ensure the required historical documentation is created and maintained to facilitate the transition between incoming and outgoing program managers. This historical documentation aids the incumbent program manager's analysis in determining trends, recurring or future program initiatives and tracking deficient program elements until corrective actions are implemented. Accountability for this task is crucial to the success of the program.

Safety Management Sub-areas with significant trends are:

SAFETY ADMINISTRATION: Individual and unit safety awards programs were neglected with few awards presented. Documentation of the adequacy of the pre-accident plan suffered, reviving previous trends of a few years ago.

INFORMATION COLLECTION: Failure to conduct and document aviation accident

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prevention surveys is a reoccurring trend. New programs or programs that are being reestablished often fail in their efforts to conduct an adequate accident prevention survey. Surveys must be conducted at least annually for the organization and for a program whenever a new program manager is appointed to any functional area or sub-area. This is the foundation for monitoring all functional areas of the organization. Programs with more frequent survey or inspection requirements such as maintenance, FOD and fire prevention tend to suffer from lack of evidence the programs are consistently monitored by the ASO.

HAZARD ANALYSIS AND TRACKING: Poorly developed hazard tracking systems, failure to discuss hazards on the hazard log at council meetings and assigning suspense dates and action officers to deficiencies identified in the council meetings is a reoccurring trend, but to a lesser extent now than previous years. The hazard tracking logs are the focal documents for the hazard tracking system and represent a window for viewing the overall success of a safety management program. Step by step, block by block written instructions must be established in the unit SOP to ensure continuity and ease of transfer of program responsibilities. New safety personnel generally have difficulty establishing and managing this simple form unless they have received hands-on assistance from an experienced safety manager. Action items identified in the council meetings must have someone assigned to address the issue and a suspense date for the corrective actions to be completed.

SAFETY COUNCILS: Often, safety council meetings were not occurring on a quarterly basis and/or council minutes did not reflect the business conducted during the meetings in sufficient detail. The requirements are quarterly safety council meetings and two years of minutes on file in the organization. The safety council's primary function is to support the safety program and assist the commander in the management of the organization. The minutes of the council provide documentation of policy implementing decisions as well as implementing control measures for hazards and command directives to correct identified deficiencies in the operating systems of the organization. The minutes are placed on safety bulletin boards for access by all unit personnel and need to be informative enough to explain the decisions of the council.

SAFETY EDUCATION AND TRAINING: Common deficiencies are: poor documentation of completed training and poor make-up procedures for missed mandatory training or failure to implement make-up training. The program requirements for aviation organizations are simple. Everyone in the organization must receive the same quality of safety training-monthly for full-time organizations and quarterly for part time (NG/RC) organizations. Safety training should be mission supportive and reflect METL tasks, deployment requirements, or other subjects to improve awareness and safe, efficient operations. Once the training is completed, retain copies of class detailed lesson plans, subject summaries, slides with detailed notes, and/or videos of safety training meetings. Provide these in a format/medium that is easily accessible to personnel for make-ups or provide additional classes/briefings for individuals who do not attend the scheduled meeting.

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Summaries should capture any additional information presented during the conduct of the meetings, i.e. commander's comments, answers to relevant questions, awards presented, discussions about relevant issues, etc. This will assure personnel who missed the scheduled safety training meeting receive all the information presented to meet the regulatory requirement of "same quality safety training for all personnel."

The FORSCOM ARMS team continues to gather, produce and update Safety Management SOPs that helps to standardize safety program processes from brigade level down to supported units. The ARMS web portal contains many "how to" examples of management techniques for various programs that are updated regularly. The level of detail in the examples may not be all inclusive for your particular unit's program and will probably need some revision, but it will provide the basis for adding your own management style. When time permits during ARMS visits, team evaluators perform safety program management training for surveyed units' safety managers. This one-on-one time with aviation safety officers (ASO) is crucial to their professional development and the commander's assurance the ASO is prepared to manage a safety program in the full spectrum environment. We view the ARMS as more than just an evaluation of the program, but we consider it a seminar – a sharing of information and mentorship to improve the program. There is no need to wait until an ARMS for this sharing of information. Contact the ARMS team members anytime there are questions regarding your program. We are always glad to help!

WE STILL WANT YOUR INPUT

Do you have an aviation related story, information brief, or lessons learned type event you would like to share with the aviation community? Pass on your experience with an article in Flightfax.

Send them via email to the Aviation Directorate, U.S. Army Combat Readiness/Safety Center:

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We can also be reached by phone – (334) 255-3530, DSN 558

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DES Flashback: STACOM 40 published 28 February 1979

"Am I my brother's keeper?"

The three most abused statements in American society are:

- "The check is in the mail."
- "My wife doesn't understand me."
- "I'll have it tomorrow."

Of equal repute are the two statements most often heard following an aircraft mishap:

- "Everyone in the outfit knew that he was the most likely one to have the next accident."
- This ranks second only to "He was the best pilot in the unit."

The statement that everyone knew he was the one to have the next accident is akin to closing the barn door after the horse has disappeared. There is concern because this problem has surfaced in accident investigations of the past. It was cited again in a recent wire strike accident which occurred outside the authorized terrain flight area.

If everyone knew, why wasn't something done about the situation? In this business you must be your brother's keeper if only out of a sense of self-preservation. As an aviator, I would not want to fly with such an individual. As an operations officer, I would hesitate to assign such an aviator to any mission. As a commander, I would have to seriously consider drastic remedial measures. The point is that apparently **everyone** did not know.

Very often some pilot-to-pilot discussion can be helpful in enlightening the errant aviator in safe and sane operation in accordance with standardized procedures and the unit's SOP. If this method is not successful, it will probably be necessary to bring in the IP/SIP; maybe his platoon leader; and in some exceptionally difficult cases, the unit commander.

The problem aviator must be recognized for what he is. He must not be kept hidden. It is incumbent upon all members of the unit to try to "turn this individual around." This is true whether the problem is air discipline, standardization, training, or unsatisfactory performance. The point is that supervisors cannot operate a viable standardization program in a void. Let's keep one another informed so that we may all maintain a high level of standardization and professionalism. •

Mishap Review: KA-300 final approach

During the conduct of a night VMC landing approach following a C-17 transport, the KA-300 fixed wing aircraft crashed two miles short of the runway. The aircraft was destroyed and all three crewmembers perished.

History of flight

The mission was a night single ship intelligence, surveillance, and reconnaissance (ISR) operation in support of theater forces. The crew of three reported for duty at 1830L, two hours before scheduled departure. They confirmed completion of the mission briefing sheet. The flight was briefed as a moderate risk due to night conditions, approach and landing environments in a mountainous region, and the PI's local flight time. The crew brief was conducted followed by a weather update and final coordination. The weather was clear sky conditions; visibility of 6,000m with mist; winds 250 degrees at 5 knots; temperature -5C and pressure altitude of 5,500 feet. Illumination was 57 percent.

Following aircraft run-up, the crew departed for their collection mission at 2041L. They maintained communication with their unit and ATC at all times and reported nothing significant for the mission duration. At 0000L the crew reported mission complete and broke station to return to base.

At 0006L the accident aircraft contacted the tower for landing instructions. The tower informed the crew they had "traffic ahead, heavy, C-17, altitude eight thousand descending. Caution wake turbulence. Report three mile final." The crew acknowledged the traffic and three mile final call and continued the approach. At 0007L the tower advised the accident aircrew that the traffic they were following had a ground speed indicating 130 knots and if they would like to 'S' turn on final it was approved. The crew advised tower they could slow down. At 0008L tower told the aircraft to report "half mile final" which was acknowledged. No further communication was reported from the accident aircraft and radar contact was lost at 0009L. At 0010L tower attempted to contact the aircraft several times with no success. Another aircraft on approach reported a large fire two miles off the approach end of the runway. Search and rescue confirmed the crash site.

Crewmember experience

The PC, sitting in the left seat, had 4,300 hours total flight time, 1,100+ hours multi-

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Engine fixed wing and nearly 600 hours in the KA-300. The PI had 1,600+ hours total time with 360 fixed wing and nearly 200 hours in the KA-300 and was also PC qualified. The sensor operator had 250 hours total time.

Commentary

The accident investigation determined that the crew flew the aircraft within two miles of the C17 and entered into the wake turbulence at approximate 400-500 feet AGL. The aircraft departed controlled flight and crashed into the ground at a high velocity and high angle of impact. The crew were fatally injured and the aircraft was destroyed.

Wake turbulence is turbulence that forms behind an aircraft as it passes through the air. This turbulence includes various components, the most important of which are wingtip vortices and jet wash. Jet wash refers simply to the rapidly moving gases expelled from a jet engine; it is extremely turbulent, but of short duration. Wingtip vortices, on the other hand, are much more stable and can remain in the air for up to three minutes after the passage of an aircraft.

Wingtip vortices occur when a wing is generating lift. Air from below the wing is drawn around the wingtip into the region above the wing by the lower pressure above the wing, causing a vortex to trail from each wingtip. Wake turbulence exists in the vortex flow behind the wing. The strength of wingtip vortices is determined primarily by the weight and airspeed of the aircraft.[1] Wingtip vortices make up the primary and most dangerous component of wake turbulence.

Lift is generated by high pressure below the wing and low pressure above the wing. As the high-pressure air moves around the wingtip to the low pressure, (high pressure always moved towards lower pressure areas) the air rotates, or creates a horizontal "tornado" behind the wings. This tornado sinks lower and lower until it dissipates.

Wake turbulence is especially hazardous in the region behind an aircraft in the takeoff or landing phases of flight. During take-off and landing, aircraft operate at high angle of attack. This flight attitude maximizes the formation of strong vortices. In the vicinity of an airport there can be multiple aircraft, all operating at low speed and low height, and this provides extra risk of wake turbulence with reduced height from which to recover from any upset. Wikipedia definition

Mishap Review: AH-64D Mid-air Collision

While conducting night security operations in support of an emergency deployment readiness exercise (EDRE), two AH-64Ds collided in flight. One aircraft made an immediate emergency landing with major damage. The second aircraft landed safely under power with significant damage. Only minor injuries to the crew were reported.

History of flight

The mission was aerial weapons team (AWT) support of a night air assault conducted as part of an EDRE exercise. The midnight insertion was located 250 miles from home station. Designated to support the assault of a planned objective (Alpha) were two AWTs with an additional AH-64D conducting a separate airborne intelligence collection mission at another objective (Bravo) located six kilometers to the west of the assault site. Flight crews attended a final air mission brief at 1600L. At 1930, the AWTs conducted an update brief. The plan called for staggered departures from home base with an initial landing at a FARP prior to the assault. The weather was few clouds at 13,000 feet with visibility of 7 miles. Winds were out of the northwest at 6 knots with a temperature of -1C. Moonrise was 0337L with illumination of 23%.

At 2045L team 1, containing accident aircraft (AA) #1 flying trail, departed home station en route to the FARP arriving at 2230L. Following refuel, the team departed the FARP to arrive on station at 2300L to over-watch objective Alpha. At 2233L AA #2 departed home station with an arrival at the FARP of 0018L. Following refuel AA #2 departed at 0035L to take up position vicinity of objective Bravo. At 2041L, AA #1, while in a slow left turn detected AA #2 in close proximity and attempted an evasive maneuver inducing a dive and right bank. Contact was made with the main and tail rotors of AA #1 with the nose and left landing gear assembly of AA #2.

Aircraft #1, with damage to the main rotor blades and loss of its tail rotor assembly, made an autorotational descent to an open field. On impact, the aircraft pivoted to the right causing the tail boom to detach, right main landing gear to collapse, and the main

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rotor blades to strike the ground. AA #2 sustained damage to its night vision system, left landing gear strut and back seat overhead canopy. The crew transitioned to NVGs, assessed damage, and landed at a nearby open field.

Crewmember experience

Accident aircraft 1: the PC, sitting in the back seat, had 1,100 hours total flight time, 1,000 hours in the AH-64D, 275 hours NVS and 700 hours combat. The PI, located in the front seat, had nearly 1,000 hours total time, 900 in the AH-64D, 360 hours NVS and 650 hours combat.

Accident aircraft 2: the PC, sitting in the back seat, had 1,500 hours total flight time, 1450 hours in the AH-64D, 380 hours NVS and 900+ hours combat. The PI, located in the front seat, had over 200 hours total time, 125 in the AH-64D and 50 hours NVS time.

Commentary

The accident investigation determined both crews failed to properly scan for other aircraft and maintain airspace surveillance. This resulted in the aircraft colliding in flight with subsequent emergency landings and significant damage to both aircraft. Additionally, the board determined there were inadequate airspace de-confliction measures in the mission planning process.

The National Transportation Safety Board released its findings on the crash of a light plane which was flying low over a residential area and struck the top of a 65-foot utility pole.

Commenting on the accident, the safety board had this to say : " A great deal of the pleasure of flying stems from a pilot 's control of an added travel dimension height. Since the earliest days of aviation, this pleasure has become-for all too many pilots-an irresistible temptation to sample the apparent thrill of low-level flight where the sensation of speed is the greatest. 'Buzzing' or ‘flat-hatting' is a deceptive thrill.

Whatever his total time, the pilot may be supremely confident of his control of the aircraft and his ability to avoid any object on the surface-until he encounters an obstruction which he couldn't or didn't see. Then he often discovers tragically just how narrow is his margin of error at low altitude.

“The safe pilot always remembers that a price he pays for the pleasure of flying is reasonable care, and adherence to minimum flight altitudes is basic to such care.“
Flightfax July 1973

Class A – C Mishap Tables

	Manned Aircraft Class A – C Mishap Table									as of 26 Mar 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	4	0
	December	2	1	0	0		1	0	3	0
2nd Qtr	January	0	0	6	0		3	1	2	3
	February	0	0	2	0		1	0	2	0
	March	2	1	5	6		1	1	1	
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	9	3	14	3

UAS Class A – C Mishap Table									as of 26 Mar 14
	FY 13					FY 14			
	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	2	7
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	5	15

The best pilot in the squadron

6 August 1980 *Flightfax*

Not long ago, as an unproductive hour at the bar wound to a close, several of my flying colleagues and I were gathered around the dregs of the last pitcher, which was rapidly approaching being too flat to drink. As is often the case when aircrew members "stand to their glasses," the conversation drifted from war stories through "where is ol' so-n-so," to memories of those no longer with us.

Some had been recruited by the airlines and some had gone to rated sup, but the talk centered on one of our number who had met an untimely end on a desert gunnery range. If there is a special eulogy for pilots, it is not delivered by a chaplain from a pulpit - it is spoken by his messmates in the bar as the happy hour crowd thins out and the beer gets warm. No congregation could be more sad-faced. No higher praise could be given. The ceremony is as predictable as any formal funeral. Sometimes there are even hymns of a sort, and green Nomex is a kind of vestment. It was an unfortunately familiar scene to most of us who had been around for a few years. Inevitably, someone said, "Yeah, he was the best pilot in the squadron." All who knew him nodded their heads in silent accord.

He certainly had been a memorable figure. He had been assigned to standboard as a lieutenant. An academy graduate, his bearing and conduct were exemplary. He knew the operators manual down to the publisher's initials and was an authority on all the "nonboldface boldface" published by the major command on down. Though he got to SEA too late for the hot part of the conflict, he extended until the very end and played a highly decorated part in the evacuations and the Mayaguez affair. He was always chosen to lead the tough missions and earned the total respect of his superiors at all levels. His exploits were legendary. He was the one who went to the development conferences and flew the test program. His physical appearance was striking, he was well ahead in his PME, he was always available when the schedule changed at the last minute, and he more than pulled his weight in the additional duty department. Besides that, he was a nice guy. No one was surprised when he was selected for major below the zone.

He was the best pilot in the squadron.

It does not pay to speak ill of the dead, but wait a minute! lf he was so good, why is he dead? At the risk of asking a sacrilegious question, how about those other well-remembered colleagues who have been honored with the posthumous title of "best pilot in the squadron?" Is there something about being the best which is fatal? What good is being the best if it kills you? What good is having the best in the squadron end up in a box when he is needed in the cockpit? Let's take another look at this paragon of pilot virtues.

He was aggressive, ambitious, and confident. These are admirable qualities - in fact, they are requirements for the job. There is, however, an important distinction between confidence and overconfidence, aggressiveness and over-aggressiveness, and even

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achievement may be overdone, or done too fast.

He had required a little command assistance to transition into a new weapons system when he did, and no one was surprised when he got it. That he was killed on a range **was** a surprise. He had a lot of low level experience. He liked being down in the weeds, and he was good at it. The investigators found nothing wrong with the aircraft. It appears that he simply flew into the ground after pulling off the target. He either didn't hear the "knock it off" call or it came too late. In any case, he got low enough to prompt a call and apparently did not react to it prior to impact.

Could there have been a malfunction? He had previously demonstrated exceptional ability to bring the aircraft home when another pilot might have landed at an intermediate point, even though maintenance would have been inconvenient and the squadron would have bought a bunch more down time. He was good enough (and mission oriented enough) to take a bird with minor discrepancies, work around them, and get the job done. He was a mission hacker. "Ya gotta be tough ... " he had said more than once. It probably wasn't a malfunction. He could have handled any malfunction small enough to be missed by the investigators.

The flight was a late afternoon launch, but there is no reason to believe that he had been fatigued. He was not a heavy drinking man and he had had no duties which would have conflicted with crew rest. Besides, during the Mayaguez mission he had demonstrated that he could perform when tired. He had flown sortie after sortie, on his own adamant insistence, even though there were more rested pilots available. He kept getting an airplane despite fatigue. After all, he was the best pilot in the squadron, and that was one tough mission. A little fatigue wouldn't have bothered him.

He bought the farm on a checkride, but stress couldn't have been a factor - he always did well on checkrides. In fact, stress may actually have improved his performance. At Kho Tang Island he earned a medal for going in on the hottest objectives. In one case, he went in a third time after being shot off twice. Now, that's stress! No, he was not one to choke under pressure.

In the final analysis the report concluded that the cause of the accident was "pilot distraction" or "disorientation" In other words, what used to be called pilot error. But errors are not something one would expect from the best pilot in the squadron. On the other hand, if he had not "gotten caught," no one would have ever suspected that he had been disoriented or distracted. He had exhibited no such tendencies, or at least none had been recognized.

But it only takes once, and it's hard to make a habit out of having fatal accidents. The diagnosis has to come before the fact in order to do any good, and it's no easy task.

The distinction between the spirit of attack and dangerous lack of caution is not always readily apparent. What passes for aggressiveness may be found to be (or at least labeled) recklessness after an accident. Spirit, however, is a prerequisite, and an excess of caution is

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self-defeating. A force of timid pilots, reluctant to take any risks, is not acceptable. Neither is a corps with the disdain for death of kamikazes (especially if training flights are required). What is required are pilots with the will to accomplish the task at hand, but the sense to recognize that a given result is not worth the loss of an aircraft and crew. This is especially true in a training environment.

During the early 70's, when Vietnamese aviation cadets were receiving primary training in the United States, one Vietnamese training officer would address each arriving class with the following safety philosophy: Each student must become the best possible pilot. That requires both nerve and skill. Since the mission doesn't end with a single sortie, a good pilot must be available to fight tomorrow. Good pilots bring both themselves and their airplanes home. Dead pilots are bad pilots. The loss of an airplane in training is as detrimental to the war effort as a direct hit from an SA-7. Sometimes it takes nerve to refuse an aircraft or abort a mission. That's part of what it takes to be a good pilot-nerve.

So what does this have to do with the pilot who is the subject of this tale? Little or nothing. Flying safety lectures will do him no good now and apparently didn‘t do him enough good when he was alive. All those monthly meetings, special briefings, and bulletin boards weren‘t enough to keep him alive. Neither were his skilled, highly trained hands and feet, vast knowledge of regulations and procedures, or extensive experience. For all his education, ability, and desirable attributes, his final professional act was costly and wasteful. He destroyed a valuable aircraft and killed its pilot. At the very best, he did not prevent the loss, and he was the last person who could have done so.

The best pilot in the squadron? He's still in the squadron. He, too, knows the books, has the skills of a brain surgeon, and reeks of moxie, but he comes home with his airplane intact. Maybe it's that little bit of extra for Mom and the safety officer. Who knows? One thing is for certain though. The best pilot in the squadron will get the job done without unnecessary losses. While he's there to fly and fight, he knows that broken birds stay on the ground and dead pilots don‘t defeat anybody.

The pilot's epitaph will, unfortunately, be occasionally intoned in the bar while the ice melts and the happy hour crowd drifts out the door with the smoke. It's a traditional way to honor our dead. But in the meantime, let's be honest - here's to the real best pilot in the squadron. The one who's still with us .

-from AEROSPACE SAFETY

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Selected Aircraft Mishap Briefs

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

Attack helicopters

AH-64D 

-Mid-air collision occurred between two AH-64D aircraft supporting separate missions. Both aircraft crash-landed. No significant injuries. Damage to both aircraft.(Class A)

Cargo helicopters

H-47 

-Aircraft's aft landing gear and ramp made contact with a 20 foot high perimeter wall during approach to land. (Class C)

Fixed wing aircraft

UC-35B 

-Crew experienced a #2 Engine N1 exceedance during altitude flight. Crew conducted emergency crosscheck procedures and aborted the mission. Engine replacement required.(Class C)

Unmanned Aircraft Systems

MQ-1 

-C series. Uncommanded high speed taxi resulted in UA striking hangar. (Class A)

-B series. On a takeoff roll the aircraft veered off the right side of the runway. The aircraft's right wing struck a taxiway sign causing damage to the wing and fuselage. (Class B)

RQ-11 

-Three minutes after launch the Raven locked into the preprogrammed waypoints no longer responding to the manual directional controls. The Raven crashed into the impact area and deemed unrecoverable (Class C)

Before you criticize OH-58D pilots you should walk a mile in their shoes. That way, when you do criticize them, you are a mile away and have their shoes.

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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