



2005-July : Newsletter

SAFETY FIRST BY-LINE – Richard Bray, Safety Committee Chair

We're on short final for the ALEA Annual Conference in Reno, Nevada. Many of you are attending the Unit Manager Course. The tuition and conference registration are complementary for the first 50 people that registered. This is part of the Safety First Program. Please take the time to visit the Safety First booth on the exhibitor floor, and attend the other safety forums and classes that are part of the main conference. I hope to meet you in Reno.

Rich

ANNUAL SAFETY SURVEYS

I wish to thank those organizations that completed the Annual Safety Survey. The information will prove very valuable in helping ALEA serve your safety needs.

If you have not completed the survey, you still have time. You can complete the survey online in about five minutes.

2004/2005 ACCIDENT UPDATE

From 1999-2004, 55% of the accidents were due to loss of control. Eighteen of the accidents occurred during emergency procedures training. In assessing the total loss of control accidents I have concluded that many accidents occurred due to the pilot becoming distracted from flying the aircraft, and being too focused on mission issues. We pilots need to first fly the aircraft.

Thirty percent of the accidents were due to mechanical failure. We can clearly do better in both categories. Overall, the accident rate was down more than 30% from the previous 5-year average. The trend is going in the right direction. Keep it up.

I reviewed the NTSB law enforcement accident reports for 2005. All of the reports except one are preliminary reports. Keeping that in mind, I have attempted to assess each accident, and offer some things to consider based upon limited information. My review is done solely with the purpose of learning what occurred and helping others from suffering similar consequences. I encourage readers to send their comments to: safety@alea.org. We can all learn.

Five of six accidents were due to loss of control. This is still the major culprit.

On June 1, a crew was operating an AS-350B2 at 200-250 feet AGL while conducting a low-level search. The pilot made a shallow downwind left turn, with the wind velocity 15-20 knots. The aircraft spun to the left and collided with the ground. It should be noted that a loss of situational awareness is often a precursor to such loss of control mishaps. A loss of tail rotor effectiveness can make recovery difficult, if not impossible, during low-level operations.

On April 27, a training accident occurred while fast-roping two officers onto a one-story building in a MD369FF. The first officer was deployed from the left side of the aircraft. The pilot decided to reposition the aircraft prior to deploying the second officer from the right side of the aircraft. While maneuvering, the pilot felt a bump. While attempting to gain altitude the nose pitched up. The pilot maneuvered the aircraft to avoid the officer on the roof, and collided with the ground in a nose-down position.

I do not know what, if any, other personnel may have been involved in the operation. I recommend having a crew chief and a ground safety officer to monitor operations. They provide extra eyes, and are helpful in identifying and mitigating hazards. It has generally been my experience that no significant advantage is gained by having more than one rope. A second rope often increases the risk of the rope and/or personnel becoming entangled.

On April 7, following an engine warning light in an OH-58, the crew landed hard while making a precautionary landing. The FAA reported no anomalies with the aircraft.

Engine instrument crosscheck and verification are essential during such occurrences. Other crewmembers can assist with this process. I recommend that all tactical flight officers be provided training to monitor engine instruments and recognize engine performance.

On January 19, a Cessna 185 was landing on a snow-covered lake. The right ski dug into the snow and the right wing and stabilizer struck the surface, resulting in substantial damage to the aircraft. There were no reported anomalies prior to the accident. The pilot had a private rating. Pilot experience is unknown at this time.

Landing on such surfaces can pose increased risk compared to landing on a prepared surface. A good before landing resonance is essential, and there is no substitute for skill, judgment and experience.

On January 18, a training flight was being conducted in a 269D. This was the first flight for a new student. The CFI flew the aircraft to a site on the airport, and demonstrated the use of the controls to the student. He then had the student hover the aircraft while he, "stayed on the controls due to the difficult nature of the exercise." One skid struck the ground and the aircraft crashed on its side.

I recommend that on the very beginning of the first training flight that the student first be allowed to perform gentle climbs, descents and turns before introducing hovering. Learning to hover is demanding and control can easily be lost with a new student. This requires vigilance in keeping the aircraft a safe distance above the ground and other surface obstacles.

It was reported that there was an accident in an OH-58 following a catastrophic compressor failure on takeoff. The accident has not been posted on the NTSB website.

ALEA Law Enforcement Accident Database allows members to search over 120 LE mishaps by agency, aircraft or probable cause.

Remember – Safety First!

Keith Johnson

Safety Program Manager