

The

Safety

Wire

June 2017

**“Go around”** is something that we do not hear enough anymore. The idea of aborting an approach, or any maneuver, tends to carry a negative undertone of failure. Nobody in this business likes to fail and we often refuse to admit failure until it is forced upon us. Unfortunately, that realization is often at a point where we no longer have a chance to prevent an incident. Recent studies back up this observation with numbers that show pilots choose to continue unstabilized landing approaches up to 97% of the time. If we peruse any number of training accident



reports, we will find a high percentage of probable cause statements cite delayed corrective action by the pilot or flight instructor. In other words, there was an effort to interrupt the accident chain, it was just too late.

Once a pilot receives a commercial pilot license, there is often an assumption that they will always steer their craft exactly where they want it to go. This is especially true for maneuvers that quickly become perceived as

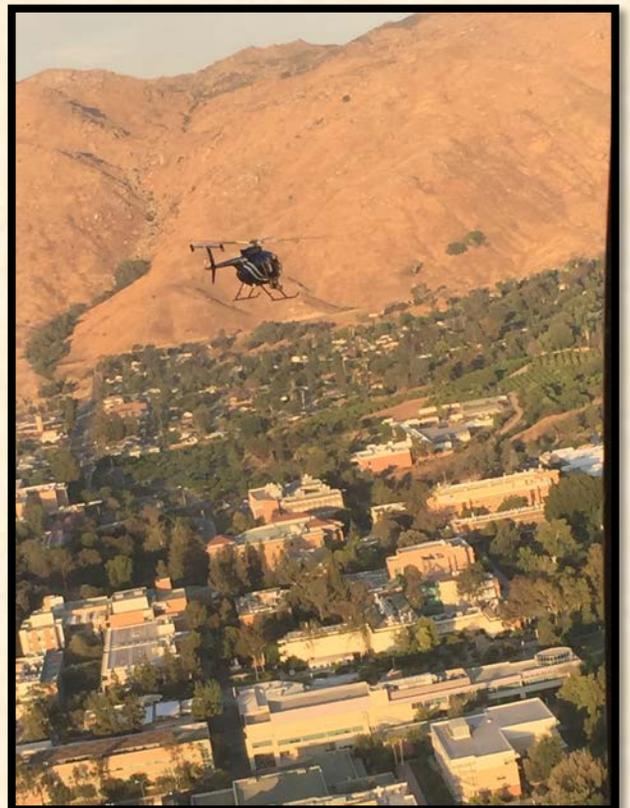
'routine', such as approach and landing. A go-around, or aborted maneuver, is not something we spend much time on in training unless we unintentionally create the need to do so.

The decision to stop a maneuver because it is not going as intended is not an indication of a poor piloting skill. Such a prudent decision is the mark of exceptionally professional pilots who demand perfection of their own actions and would rather start over while still being well within the envelope of aircraft control. We must remove the stigma of negativity surrounding go-arounds.

This year, the ALEA safety program is putting additional emphasis on loss of control (LOC) accidents. In the last five years, we have had 31 LOC related accidents resulting in 15 fatalities. Many of those accidents could have been prevented with a well timed go-around. To address this, I would like to propose we all consider two small changes to our operations:

1. Practice go-arounds during routine operations. Once in a while, even when an approach or maneuver is going as planned, execute an abort for practice. Make the procedures normal and keep them fresh so there are no second thoughts when there is even the slightest question about initiating a go-around.
2. Make it a regular training maneuver. Do it more than once and at different times in the maneuver. Don't always call for a go-around at the same time on short final. Consider other maneuvers that could benefit from the practice of identifying when an abort should be initiated.

I'm not suggesting this be done once or twice a year. That is not often enough to make changes in our habits and behavior.



Like any kind of training, we would all benefit from the regular practice of calling out 'go around' for no reason other than the objective of self-preservation.

*“Previous experience has always shown that there is a way to remove seemingly insuperable barriers when the proper time comes.”*

*~ Clarence 'Kelly' Johnson  
Lockheed Aerospace*

## *Recognizing Professionalism*

Over the past month, ALEA members have been involved in some fantastic training events around the world. These are the kinds of meetings that drive our profession up to higher levels of both safety and mission capability. For those concerned about complacency, these kinds of events are the best cure there is. In anticipation of ALEA Expo in Reno, NV next month, I'd like to recognize the following organizations:



ALEA Safety Awards presented at the Minnesota Department of Natural Resources Enforcement Division annual award ceremony. From left to right: DNR Commissioner Tom Landwehr, Conservation Officer Pilot Jason Jensen (Silver level), Conservation Officer Bob Geving (Bronze level), Chief Pilot Captain Tom Buker (Silver level) and DNR Enforcement Director Col. Rodmen Smith.



During the recent Riverside County Sheriff's Office annual training day, Chief Pilot Mike Calhoun presented the ALEA Flight Safety Platinum award to Deputy/Pilot Deputy Chad Marlatt for more than 5000 accident and violation free flight hours. The event was attended by more than 80 people from numerous agencies, including: LAPD, LASO, San Diego PD, San Diego SO, Long Beach PD, 3 divisions of CHP, Orange County SO, and Pomona PD.



2017 Orlando Area Public Safety training day. The Seminole County Sheriff's Office hosted an annual meeting for agencies in the Orlando area to discuss interagency coordination and local area operations as well as training, tactics and safety.





The 2017 Police Aviation Conference (PAvCon) was held in Doncaster, UK June 5-7. ALEA members from Europe, North America and even Australia attended the three-day event.

## ***Practical SMS***

We are half way through 2017 already. Now is a good time to update everyone on how the safety program is doing. The unit routinely needs to be updated on the accomplishments of the program, the progress towards the objectives and goals, status of hazards, and what the next steps are. People often lose interest, and confidence, in the safety program when they lose track of what is happening with it. A mid-year report does not need to be extensive. As a matter of fact, I suggest it's a 1-3 page report, at most, depending on the size and complexity of your program. The report should include, at a minimum:

- The current unit goals and objectives, especially those specifically focused on safety (though safety should be a part of EVERY unit goal and objective).
- Progress on the objectives.
- Current hazards being addressed and the risk control in place. This will include reported hazards and incidents during this time period.
- Performance of any risk control addressing the current hazard list. How is it working? Has it been implemented yet? If not, why and when will it be?
- FRAT data and trends.
- Plans for the second half of 2017.

## Resources

### US Helicopter Safety Team - 30 Seconds for Safety

<https://www.youtube.com/watch?v=1jpFZWWtkvc>

### IHST Safety Bulletins

<http://www.ihst.org/Default.aspx?tabid=3089&language=en-US>

### Police Aviation News

<http://www.policeaviationnews.com/Acrobat/254June2017PANews.pdf>

### Aviation Human Factors newsletter

<http://www.decodinghumanfactors.com/home.html>

### European Helicopter Safety Team

*Training and Testing of Emergency and Abnormal Procedures in Helicopters*

[https://essi.easa.europa.eu/ehest/wp-content/uploads/2011/05/EASA\\_EHEST\\_HE\\_11.pdf](https://essi.easa.europa.eu/ehest/wp-content/uploads/2011/05/EASA_EHEST_HE_11.pdf)

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## ALEA Online Meetings

The schedule for upcoming ALEA online meetings is as follows.

If you would like to join, send an email to: [safety@alea.org](mailto:safety@alea.org)



### UAS:

Thursday, July 27, 2017

16:00 PM - 17:30 PM EDT (2000 UTC)

### Safety Officers:

Thursday, July 27, 2017

16:00 PM - 17:30 PM EDT (2000 UTC)

### Maintenance:

Wednesday, August 16, 2017

1:00 PM - 2:00 PM EDT (1700 UTC)

*“Research should be defined as doing something that half of the people think is impossible. So what that means is that a true creative researcher has to have confidence in nonsense”*

*~ Burt Rutan*

## **Reality Check...**

**Note:** The following reports are taken directly from the reporting source and edited for length. The grammatical format and writing style of the reporting source has been retained. My comments are added in **red** where appropriate. The goal of publishing these reports is to learn from these tragic events and not to pass judgment on the persons involved.

**Aircraft:** EC130 B4  
**Injuries:** 1 Fatal  
**NTSB#:** CEN15FA164

[https://www.nts.gov/layouts/nts.aviation/brief.aspx?ev\\_id=20150308X10201&key=1](https://www.nts.gov/layouts/nts.aviation/brief.aspx?ev_id=20150308X10201&key=1)

The emergency medical service (EMS) helicopter was landing on a privately owned elevated heliport to pick up two medical crewmembers. The medical crewmembers had been dropped off with a patient on a preceding flight. During the preceding flight, the nurse thought about telling the pilot to abort the landing on the heliport because there was a lot of rolling and yawing, and he was having a hard time landing the helicopter. After the landing, the nurse and another medical crewmember stated that the pilot did not want to depart the heliport, but the medical crewmembers told the pilot that there may be potential arrivals of other EMS helicopters. The pilot chose to depart the heliport and obtained fuel at the operator's base of operations. For the return flight to pick up the two medical crewmembers, the wind had increased, and the helicopter approached the heliport in high-wind conditions and with a right, quartering tailwind. Also, the wind along with the surrounding buildings likely created a turbulent airflow/windshear environment in which the helicopter was operating as it approached for landing. The helicopter's operation in a high-power, low-airspeed condition in high-wind conditions, including a right quartering tailwind, likely resulted in a loss of control due to settling with power.



Photo 1 – Main wreckage of the helicopter located near the west parking lot entrance of the hospital.

A security video showed the helicopter on a northerly flightpath descending at about a 45-degree angle before

impacting the ground and coming to rest on an approximate northerly heading. The pilot sustained fatal injuries due to the subsequent fuel tank fire/explosion, which otherwise would have been a survivable accident. A postaccident safety evaluation of the heliport showed that the final approach and takeoff area/safety area were obstructed by permanent and semi-permanent objects that pose a serious hazard to helicopter operations. These obstructions limited the available approach paths to the heliport, which precludes, at times, approaches and landings with a headwind.

The National Transportation Safety Board determines the probable cause(s) of this accident as follows:

The pilot's decision to land during unfavorable wind conditions, which resulted in a loss of control due to settling with power. Contributing to the accident were the lack of an adequate approach path due to numerous obstructions and the lack of available guidance regarding the helicopter's performance capabilities in the right quartering tailwind condition.

**Aircraft: AS350 B2**  
**Injuries: 1 Fatal: 2 Serious**  
**NTSB#: CEN15FA171**

[https://www.nts.gov/ layouts/nts.aviation/brief.aspx?ev\\_id=20150313X72113&key=1](https://www.nts.gov/layouts/nts.aviation/brief.aspx?ev_id=20150313X72113&key=1)

The commercial pilot was conducting a positioning flight back to the base after conducting an emergency medical services flight during which a patient was transported to a hospital. According to one of the two medical crewmembers onboard the flight, the crew checked the weather before the flight, and the report showed ceilings at 8,500 ft. and 6 miles visibility at their intended destination and ceilings at 10,000 ft. at the departure location. During the flight to transport the patient, the pilot stated that the clouds above their cruise altitude were lower than he expected. The pilot descended the helicopter and landed it at the hospital helipad without incident. While on the ground, the pilot checked the weather conditions again, and they were the same. After the pilot conferred with the medical crew per

their risk management procedures, they decided to return to their base as planned.

During the accident flight, the helicopter was southbound at a cruise altitude of about 1,500 ft. mean sea level (msl) in an area with a terrain elevation of about 700 to 900 ft. msl, and dark night visual meteorological conditions existed. According to the medical crewmembers, about midway to their destination,

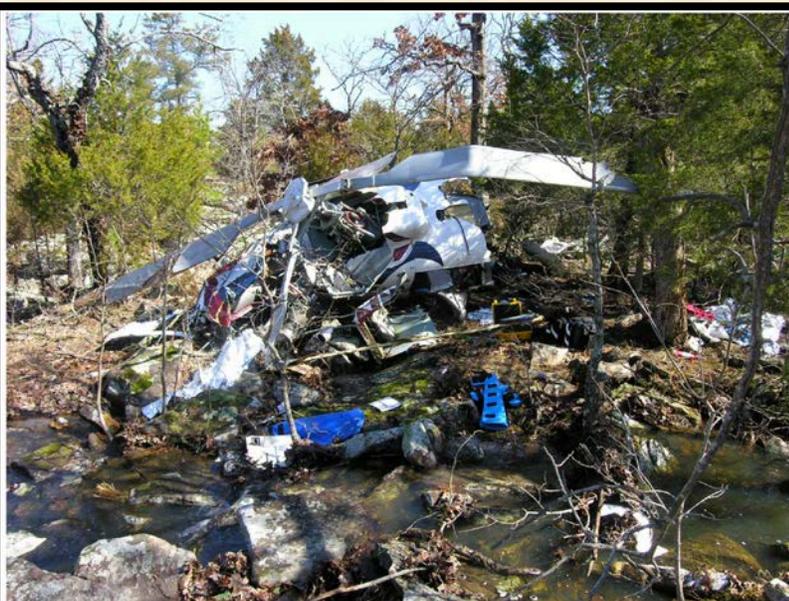


Photo 1 – Helicopter Main Wreckage

the helicopter entered instrument meteorological conditions (IMC). After a brief discussion, during which one of the crewmembers told the pilot to go "up," the pilot stated he was going to divert to another airport because he saw lights, and he then began a left turn.

Although both crewmembers reported seeing trees and one of them told the pilot to "pull up," shortly after, the helicopter impacted trees and terrain atop a wooded hill at an elevation of about 840 ft. msl, which resulted in the separation of the tailboom and portions of the fuselage; the main wreckage came to rest on its right side. It is likely that the pilot experienced spatial disorientation during a turn after inadvertently entering IMC, which resulted in the helicopter descending into trees atop high terrain.

Zolpidem, which is a prescription hypnotic medication used to treat insomnia and may impair mental and/or physical ability required to perform potentially hazardous tasks such as driving or operating heavy machinery, was detected in the pilot's blood and liver.

The National Transportation Safety Board determines the probable cause(s) of this accident as follows:

- The flight's inadvertent encounter with night instrument meteorological conditions, which resulted in the pilot turning the helicopter and subsequently descending into trees and terrain due to spatial disorientation.

*There are no new ways to crash an aircraft...*

*...but there are new ways to keep them from crashing.*

Safe hunting,

**Bryan 'MuGu' Smith**

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