Complacency is consistently a top concern reported by APSA members in our annual Safety Survey. If we look at the most frequent 10 responses to the question, “What are your top three safety concerns?” we see that many of them are adding fuel to the complacency flame. In 2018, the main concerns on the survey, in order, were:

1. Training
2. Fatigue
3. IIMC
4. Maintenance related concerns
5. Complacency
6. UAS mid-air collision
7. Unit/Agency management
8. Aircrew inexperience
9. Mid-air collision with manned aircraft
10. Wire/object strike

I used to think that showing up to work and doing my job to the best of my ability was enough to keep complacency at bay. Unfortunately, I learned that is not enough. A chef who uses their favorite knife in the kitchen every day will, over time, find that knife begins to dull, no matter how expertly they use it. Once in a while that chef must take time to clean and sharpen the knife, even though this may take from the time they have to use that tool to for its purpose. The same is true of our skills as mechanics, aviators, administrators, etc. The problem is, I can get so wrapped up in my daily work that I don’t realize my edge has become dull until it fails me.
We can see from the list above that fatigue is a major concern. If we are tired from either lack of sleep, or a relentless workload, we invite complacency. Even if fatigue doesn’t prevent us from recognizing the dulling of our skills, we are not likely to have the energy to do much about it.

Complacency is a common contributing factor in maintenance related incidents, IIMC and wire strike accidents. Again, the problem often grows in our day-to-day work, operating in the same area, flying or working on the same aircraft, answering the same calls, etc. Without a break from our ‘normal’ operations to sharpen our skills, we may not see complacency sneaking up until it is too late.

One of the most potent cures for complacency infections is also on our list. Training can sharpen our skills, refresh our perspective and add new cutlery to our arsenal of abilities. Too often, we look at training as a painful, even boring, drudgery that we have to do to meet someone’s administrative requirements once or twice a year.

Training is so much more than that. It is reading this newsletter, Air Beat, or some other print or digital resource. Training is going to the publicsafetyaviation.org website to look for news or resources. It is attending a seminar, conference, or just a pancake fly-in breakfast. It is making an instrument approach back to the airport instead of simply flying straight back to the hangar. Training is all these things and more.

Keeping our skills healthy and free from complacency contamination is like exercise. As it is with exercise, training will not make an impact if we only do it a
I fly because it releases my mind from the tyranny of petty things.

~ Antoine de Saint-Exupery

**ONLINE MEETINGS**

APSA conducts regularly scheduled online meetings for safety officers, maintenance technicians, UAS operators and those involved in SAR via a conference call you can join using your computer, mobile device or phone. Online meetings are open to any APSA member. Contract maintenance providers to APSA members are welcome to participate in the maintenance meeting as well.

The schedule for upcoming APSA online meetings is as follows.

If you would like to join, send an email to: safety@publicsafetyaviation.org

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<thead>
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<th><strong>Safety Officers:</strong></th>
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<td><strong>Friday, May 10, 2019</strong></td>
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<th><strong>SAR:</strong></th>
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RESOURCES

NASA Callback - Communications:  
https://asrs.arc.nasa.gov/publications/callback/cb_471.html

Human Factors Newsletter:  
https://www.decodinghumanfactors.com

Aviation Safety Network – Database:  
https://aviation-safety.net/database/

Education is the kindling of a flame,  
not the filling of a vessel.  

~Socrates

EMERGENCY PROCEDURE OF THE MONTH

In each monthly emergency situation, discuss what you would do, as a crew, to respond to the following emergency. If the EP does not apply to your specific aircraft, think of something similar.

NVG failure below 50’ AGL on approach to unlit LZ

Or...

Landing light failure on short final to runway

Digital mapping system freezes up during a call
Practical SMS

June is approaching, which marks the half-year mark on our calendars. Now is a good time to start putting together a short mid-year SMS report for your unit. It is an opportunity to refresh everyone on the issues being addressed, objectives set at the beginning of the year, and plan for the last half of 2019. In your report you should cover:

1. The 2019 Safety Objectives, and progress towards meeting those targets.
2. Active hazards being addressed by the safety program (reported hazards, inspection/audit items, etc.).
3. Safety training (initial SMS, recurrent training, IIMC, etc.).
4. Mid-year inspections or audits conducted in the first half of the year.
5. Game plan for July-December.

Be sure to cover the most important items in a short ‘executive summary’ that is no more than one page. If you have details that require more space, carry it onto the second page. Use graphs and other images as much as possible. If you have the option, color is better. On the first page, used numbered lists, not bullet points, as we tend to scan bullets faster and miss information.

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: Bell 206L-3
Injuries: 1 Minor
New Zealand TAIC#: AO-2011-001
On 20 January 2011, the pilot of a Bell 206L-3 LongRanger helicopter ditched the helicopter after experiencing a significant engine power reduction while in the cruise. The pilot did not have time to make an emergency radio call, but the accident was witnessed by people on shore. The pilot was not wearing a life jacket and spent more than 2 hours in the water before he was rescued. He suffered minor injuries only.

The pilot said that he flared normally to reduce the rate of descent before applying full collective pitch to cushion the water entry. He said the landing was “firm”. The pilot then rolled the helicopter to the right to allow the main rotor blades to strike the water and stop turning. He said the rotor striking the water had a harder impact. The forward windscreens and chin windows then broke and the cabin filled with water as the helicopter rolled inverted. The helicopter was not equipped with emergency flotation gear, but initially floated just below the sea surface. The pilot had had no training in escaping from a submerged helicopter and he experienced some disorientation before he managed to escape from the cabin. He clung to the landing skids for less than 15 minutes before the helicopter began to sink. He was not wearing a life jacket and had none on board. He began to swim towards the shore, using his helmet and pieces of main rotor blade for flotation, and was aware of swimming through floating fuel. A number of witnesses on or near Waipu Beach saw the crash and reported this to Police at about 1217. A large arrow pointing towards the impact point was drawn in the sand to guide search aircraft, but the reported distance offshore was overestimated. An Air Force Orion maritime patrol aeroplane that was operating in the Hauraki Gulf was diverted to the search. The witnesses passed advice through Police to guide the Orion towards the accident site. Witnesses and search personnel said there was an on-shore easterly wind with white caps on the sea. In spite of the sea condition, the pilot was found by the Orion crew at 1422, approximately 1500 metres (m) offshore, and a rescue helicopter from Whangarei rescued him soon afterwards. He suffered mild hypothermia and minor bruising, as well as fuel burns to exposed skin.

The helicopter was not able to be recovered from the sea for about one week. The cause of the reported engine power reduction was not determined.

The pilot did not take appropriate survival precautions for a flight that was intended to be operated over water. His rescue was greatly assisted by the accident being witnessed and by a favourable on-shore wind.

The following key lessons were noted:
1. Pilots should have a flight-following arrangement or submit a flight plan for every flight to ensure that a search is started without delay should the flight become overdue.

2. The occupants of single-engine aircraft operating at low level over water should wear, not just carry, life jackets when they plan to fly beyond gliding range of a suitable landing place.

3. When a forced landing appears likely, pilots should activate the emergency locator transmitter as soon as possible and make an emergency radio call.

4. Helicopter pilots who frequently operate over water should undertake helicopter underwater escape training.

Aircraft: Airbus H130
Injuries: 3 Uninjured
NTSB#: ERA16LA098


On January 29, 2016, at 1303 EST, an EC130 B4, operated by Air Methods Corporation, was substantially damaged when the left rear entry door departed the airframe while airborne. The commercial pilot and two medical flight crewmembers were not injured. Visual meteorological conditions prevailed.

In cruise flight, about 5 minutes after takeoff, the pilot felt and heard an increase of wind in the cockpit. He scanned both front windows to see if they were ajar and, as he faced straight ahead, he heard and felt a rush of air, thinking that the left rear sliding door had opened. As the pilot turned to look, he heard a "whoosh" and saw what he thought was a clipboard depart the helicopter and angle away from the tail (about the 7 o'clock position).

At that point, the pilot slowed the helicopter and instructed the specialty nurse to try and close the door. She seemed to be having some difficulty, so the pilot suggested that the door may have "locked back" and to use the lock release so she could slide the door forward to the closed position. After a few seconds, the specialty nurse announced that the door was missing, and that's when the pilot realized that the clipboard he saw was in fact the door.

With no abnormal flight characteristics, the pilot then diverted the helicopter to nearby Tri-State Airport (HTS), Huntington, West Virginia, and landed uneventfully. After shutdown, a visual inspection revealed damage to the left transmission hatch, one rotor blade, and the plastic sliding door guide on the left side baggage door.

The flight nurse also noted that she observed the specialty nurse slide and latch the door before takeoff. During the flight, when she heard a loud wind noise, she looked left to see that the door was open. After the specialty nurse received instructions from the pilot about unlocking the door ("when it opens, it locks for safety") the specialty nurse looked back and stated, "it's gone."

According to a maintenance log notation, on September 20, 2015, maintenance was completed in response to, "left rear sliding door would not open."
There are no new ways to crash an aircraft…

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

Safe hunting,
Bryan ‘MuGu’ Smith
Safety@PublicSafetyAviation.org
407-222-8644