AIRBORNE LAW ENFORCEMENT ASSOCIATION

The Safety Wire

October 2014

Boss, I'm tired...

Now what? Ask yourself what your agency would do if a unit member told the manager that they didn't get the rest that is expected of them, either by policy or plain common sense. Your answer will tell you how effective your agency's fatigue management program is.

By now, most of us have heard about the dangers of fatigue. I recently read an article about a military study that showed fatigued soldiers operated the same as if they were intoxicated. All I thought was, *old news, tell me something new.* I imagine most of you would feel the same. Most of our agencies have crew rest policies. Yet, we still see fatigue as a major factor in many incidents. When I poll attendees at ALEA events at ALEA events about hazards that concern them, fatigue is always one of the leading issues. How can this be if we are all so aware of the dangers of fatigue and there is policy requiring crew rest?

Fatigue is a prime example of the dangers in having separate safety and operational policies. The rule is put on paper, but not worked into the operational framework. If flight crewmembers or maintenance technicians find themselves outside of the crew rest policy, they need to be comfortable telling management that they are. The only way they will be comfortable doing so is if there is a plan in place to deal with it.

Really, there are only two choices. The first choice is to leave the position open until the person can get the required rest. Is your agency prepared to go for part or all of a shift without the aircraft or maintenance? If not, the other choice is to

staff the unit so backup is available if someone cannot work due to fatigue, illness, etc. If you do not have one of these two plans in place, your fatigue policy is doomed to failure.

Just Culture must be in place so employees do not fear reporting the safety hazard. Proper Safety Culture would not protect an employee from abusing the fatigue policy to gets days off or habitually mismanage their schedule, however.

We are all human. Eventually, we will all have something come up that keeps us from getting enough sleep before a shift. Sick kids, stress, illness, and construction during the day or loud parties at night down the street are just a few that have kept me from getting enough sleep. If we know that our buddy will have to hold over and work a double shift, the boss will be mad, there is a big operation that day, or the unit is expecting a major repair to be completed, our best intentions will get the best of us, setting the stage for a major incident.

The first thing to go when we are fatigued is our decision-making ability, not our motor skills. However, we often evaluate our fatigue based on those motor skills, so once they start to show signs of degradation, we are already well into an unsafe state of fatigue. We need to protect ourselves with effective policy backed-up by a reasonable and thought-out contingency plan.

So ask yourself, what will happen if I “call in tired?” If you don’t like the answer, something needs to be fixed before someone gets hurt.

The reasonable man adapts himself to the world;
the unreasonable one persists in trying to adapt the world to himself.
Therefore, all progress depends on the unreasonable man."

~ George Bernard Shaw

Safety Stand Down

Last month, I asked all ALEA members to conduct a safety stand down this fall. This is in response to the increased number of accidents law enforcement aviation has historically suffered in the autumn. Look up last month's safety newsletter for ideas on topics to cover. Please email me if I can help you facilitate your safety stand down, or to tell me how yours went. safety@alea.org

Safety Officer Mutual Aid

During the last online ALEA safety meeting, we discussed the recent increase in temporary weather towers, NVG maintenance and several new NTSB recommendations for law enforcement aviation. For a copy of the minutes, please email me.

The next ALEA safety online meeting will be on December 12th. Please send me an email if you are not on the mailing list and would like to attend. safety@alea.org

Dec. 12th, 2014
3:00pm EST (1900UTC)

"There's a big difference between skill and judgment"

~ Kurt Robinso

I know that many of you qualify for this award….please nominate someone who's great decision making deserves recognition.

Introducing the
Rotorcraft
"Moral Courage Safety Award"
MCSA

Supporting the HAI
"Land & Live"
philosophy

The Moral Courage Safety Award is presented by the International Society of Safety Professionals (ISSP). The ISSP is a US registered non profit organization dedicated to advancing safety in all industries.

2015
Call For Nominations

The purpose of the award is to promote and foster positive safety culture in the rotorcraft industry by recognizing those individuals and organizations that make sometimes difficult operational decisions based on continued safe operations.

Example of a deserving individual and organization – I learned of a HEMS pilot who aborted a critical neonatal transport because of unforecast bad weather. It was a tough call and one that haunted him. He made a difficult decision to ensure a safe outcome. His organization supported the decision and went so far as to recognize him for making the tough call. In this case both the individual and the organization should be recognized.

Let's face it; it's easy after the accident to second guess the decisions that put a crew in trouble. What our industry needs is to reward those who make the tough decisions that keep them out of trouble. That's walking the talk of positive safety culture!

Sometimes choosing the safest course of action can be difficult, especially if it means modifying the mission. Bottom line, it takes ***moral courage*** to do the right thing.

What is Moral Courage?

"Moral courage is the courage to take action for moral reasons despite the risk of adverse consequences. Courage is required to take action when one has doubts or fears about the consequences."

Unfortunately some are criticized, even punished for making a safety call. We need to change that mentality; change our culture. The MCSA does that!

Who is eligible?

Any Crew, Crew Member, Maintainer, Supervisor, Manager, employee and or their organization who demonstrate, by their actions, commitment to making a safety call, fostering a positive safety culture.

To obtain a nomination form simply email the individual below.

2015 Nominations must be received no later than 15 January 2015.

The award is presented at the 2015 Heli-Expo. Presence requested but not required to receive the award.

Email Mr. D Smith for a nomination form. kwpilot58@gmail.com Or call (US) 405.694.1644

Resources

Police Aviation News:

http://www.policeaviationnews.com/Acrobat/221PANewsSept2014.pdf
http://www.policeaviationnews.com/News_Archive.htm

Training and safety resources from the European Helicopter Safety Team:

http://easa.europa.eu/essi/ehest/main-page/training/

NASA Safety Newsletter (October - Non-towered airport ops):

http://asrs.arc.nasa.gov/publications/callback/cb_417.html

HeliHub Safety news page:

http://helihub.com/Safety/

"Our doubts are traitors, and make us lose the good we oft might win, by fearing to attempt."

~ Shakespere
Measure for Measure

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.*

Story on recent HEMS accident in Wichita:

http://www.aero-news.net/index.cfm?do=main.textpost&id=1f064ed6-5db6-4756-97a7-6eebede7bad4

Aircraft: Bell 407
Injuries: Minor
Canada TSB Identification: A13F0161

The Kenyan Administration Police Service Bell 407 was conducting a security mission near Mombasa, Kenya. Shortly after departure from a refueling stop, the pilot noticed an eng chip caution light illuminate. The crew landed and the engineer on board removed the lower chip plug, identified a small number of chips, and wiped the plug clean. He re-inserted the plug and the crew took off. After a few minutes, the eng chip light illuminated followed a few seconds later by a loud bang. The pilot reports he saw, "low rotor rpm and audio, eng out and check instrument lights." He also noticed the engine oil pressure indication on the gauge dropping. The pilot entered an autorotation to maintain rotor speed. The helicopter made contact with the ground with a very high rate of descent. The helicopter sustained substantial damage while the crew and passengers sustained minor injuries.

Aircraft: Pilatus PC-12
Injuries: None
Canada TSB Identification: A14C0032

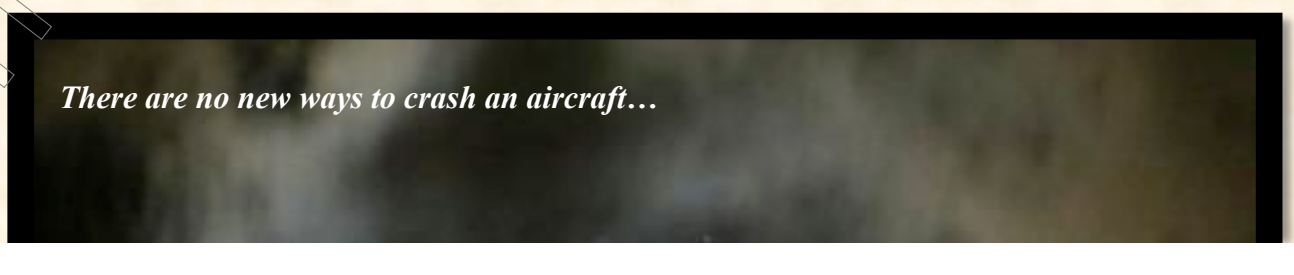
The RCMP Pilatus PC12 aircraft was issued a descent clearance from 15000 feet to 10000 feet. Opposite-direction traffic, a Beech 1900, was cruising at 14000 feet. While descending through 14000 the Beech 1900 received a TCAS indication and soon after the pilot had visual contact with the Pilatus. At the same time Pilatus also received a TCAS warning and had visual contact with the Beech. The aircraft were separated by 3.5 mile lateral separation. The Beech was then given a clearance to descend to 13000 feet. Both aircraft initiated turns to the right for avoidance and at approximately 13000 feet the aircraft passed with a .3 nm lateral separation and 300 feet vertical separation.

Aircraft: Bell 206 L-1
Injuries: 3 Fatal
NTSB Identification: ERA13FA273
http://www.ntsb.gov/aviationquery/brief.aspx?ev_id=20130607X04715&key=1

The air ambulance repositioning flight was en route to base following a patient transfer. Weather information forecast about 3 hours before the accident indicated a moist environment; however, visual conditions were anticipated around the time of the accident. An updated forecast was published about 10 minutes before the accident, and it indicated that fog or low stratus cloud development was possible and that visibility could decrease to near or below airport weather minimums in the early morning hours. Witness statements and the reported weather conditions indicated that patchy fog had developed near the helipad at the time of the accident and that visibility at the accident site was 1/4 mile; however, the specific visibility conditions encountered by the helicopter during its approach could not be determined. A witness reported seeing the helicopter "flying lower than normal" and then spinning before impact. Another witness reported seeing the helicopter in a nose-down attitude and then impact the ground.

The wreckage was located in a school parking lot, which was about 750 feet from the landing pad. The wreckage distribution was consistent with an in-flight separation of the main rotor and tailboom. An examination of the helicopter airframe, engine, and related systems revealed no preimpact anomalies that would have precluded normal operation. Both the main rotor assembly and tailboom separated in overload.

Review of GPS data showed the accident helicopter descending in three right circuits near the landing pad just before the accident. The maneuvering flight path of the helicopter before the accident was consistent with an attempt to avoid fog followed by a loss of control. Although the pilot was instrument rated, he had not logged recent instrument time. Further, although the pilot had recent training in night vision goggle usage and had night vision goggles available during the flight, it could not be determined if he was using them at the time of the accident. Given the reports of fog in the area and the accident circumstances, it is likely that the pilot entered instrument meteorological conditions during the approach to the helipad, which resulted in spatial disorientation and loss of control.



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

Safe hunting,

Bryan 'MuGu' Smith

safety@alea.org
239-938-6144