



# AIRWARD NEWS

In Recognition of Professional Performance during a Hazardous Aviation Event or Significant Contribution to Aviation Mishap Prevention

January/December 2007

## What would you have done?

On July 3, 2007 the Arizona Strip helitack crew was dispatched to the Barnes Canyon Fire in eastern Nevada. While en route to the fire, pilot Chuck Robbins of Sundance Helicopters noticed that the NF gauge of his AS-350B2 helicopter was fluctuating and had spiked into the red. With over 3000 hours in the AS 350 Chuck knew that the aircraft manual required him to land the helicopter as soon as possible. Chuck selected a suitable area, made a precautionary landing, and once the aircraft was safe on the ground he double-checked the aircraft manual. The landing site Chuck selected allowed him to use his cell phone to contact Sundance's Maintenance Department to confirm his actions. The mechanic at Sundance gave Chuck a series of checks to troubleshoot the problem and once finished Chuck ran the helicopter up and determined that nothing was out of order.



After talking to the mechanic again, Chuck was cleared to fly the helicopter back to the St. George airport. However, Chuck and the helicopter manager, Cory Johnson, discussed the situation and made a good risk decision for the government employees to hike out and be picked up instead of flying back with the helicopter. Dispatch was informed of the situation and the decision that the helitack crew would hike the nine miles to the nearest road for pickup. Even though it was determined by the specifications in the aircraft manual and approval by the company mechanic that the helicopter was fit for flight, the helitack crew took a more conservative approach by deciding to avoid the risk by hiking out instead of flying on the aircraft.

This entire situation is a great example of alertness and knowing your equipment, managing risks and taking a conservative approach when alternatives presented themselves, Crew Resource Management (CRM) and excellent communications by the pilot, the mechanic, and the helitack crew. Chuck Robbins, Cory Johnson, and helicopter crewmembers Lance Jorg and Mike Dargatz are commended for setting a great example of professionalism and teamwork when making decisions regarding aviation safety. Kudos to the entire aircrew!

SAFECOM 2007-0434

## A Towering Achievement



COFMS UAO Chris Hice

At the beginning of the 07 fire season Chris Hice, the Central Oregon Fire Management Services Unit Aviation Officer (COFMS UAO), took on an active role assisting his Regional Aviation Safety Manager (RASM) and Fire Information Technology Specialists in developing electronic aerial hazards maps for the Pacific Northwest area.

Chris did a yeoman's work by planning and including the input from Unit Aviation Managers and others to develop a high quality product. In developing the electronic aerial hazards maps, Chris came across a disturbing development that meteorological evaluation towers (MET) are being

built throughout the west. The meteorological evaluation towers are used to measure wind speed over a 3-year period to determine if an area is suitable for a wind farm. The permit process for these towers is not set up to inform the aviation community if the hazards are below 200 feet. Many of the developments are on private property, so the permit process is not associated with land management agencies. To make avoiding these MET towers even more difficult, the towers are of differing heights, but generally just below the FAA threshold and therefore they are not lit.

Chris went the extra mile to research these towers, find out where existing ones were, and obtain locations of potential wind farm sites. The information Chris discovered on wind towers was brought up at a Regional Aviation Awareness Meeting attended by aviation managers, dispatchers, fire managers, military personnel and other professionals in the wildland fire community.

Chris' work went beyond Oregon and Washington and was used as a catalyst for others to investigate these towers in other states. Thanks Chris for seeing the dangers these towers pose to our aircrew and doing something about it. Great job!!

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## Operational Risk Management in Action

In support of the Shelton Fire, James Daniel the pilot of a SEAT declined the last mission of the day based on his judgment of sun angle, drift smoke between the incident and the SEAT Base and available fuel to reach an alternate airport. The SEAT manager notified dispatch and a message was passed along to the Air Attack on scene.

This pilot's situational awareness and risk assessment beyond mission accomplishment is the operational level of what an aviation "safe attitude" is all about. This is a good example of Operational Risk Management by the pilot.

Kudos Daniel and Thanks! [SAFECOM 2007-0783](#)



Pilot James Daniel

## From the Classroom to the Real World

Mr. Fontenot, Mr. Guillory, and Mr. Olive directly contributed to an increase in the safety posture of Minerals Management Service (MMS) aviation operations in the Gulf of Mexico region. Their actions demonstrated an effective use of the Department of the Interior's Aviation Safety Program processes and began a series of actions that will culminate with a material improvement in the level of safety for all MMS inspectors flying in the Gulf of Mexico.

Following completion of recurrent Helicopter Underwater Egress Training (HUET), Mr. Fontenot applied new knowledge gained during training to identify a shortcoming in seatbelt configuration of off-shore helicopters used by MMS on a daily basis. Mr. Fontenot, Mr. Guillory, and Mr. Olive, then through a collective effort, conducted a detailed surveillance of daily flight operations and took action to formally document the shortcoming by completing a DOI Safety Communiqué report (SAFECOM) and recommending corrective action.

*By proper application of safety processes, from scheduling and conducting recurrent safety training through application of knowledge gained and use of the Department's formal aviation safety reporting system, Mr. Fontenot, Mr. Guillory, and Mr. Olive serve as an example for all DOI employees to emulate.*



From left to right: Jarrott Guillory, Eric Fontenot & Bill Olive

The shortcoming and the life-saving potential of the recommended corrective actions were provided in the SAFECOM narrative: "Lake Charles has three aircraft. Of the three, the seatbelt arrangement is the same in two of them. That leaves one that is different. Two of the aircraft have seatbelts in the rear that buckle from inside to outside. However, the other one has seatbelts that buckle from outside to inside. Our inspectors fly in all three of these aircraft on any given day. After going through HUET training last week, it was made

clear that uniformity in seatbelt configuration can and will greatly increase your chances of egress should a ditching (inverted) situation occur. This is a small modification that could be the difference in someone making a successful underwater egress and saving a life."

Mr. Fontenot, Mr. Guillory, and Mr. Olive's actions demonstrate a commitment to the conduct of safety training, the foresight to apply training lessons learned to daily operations, and ultimately a full commitment to increasing the level of safety for the entire MMS Gulf of Mexico inspector cadre. By proper application of safety processes, from scheduling and conducting recurrent safety training through application of knowledge gained and use of the Department's formal aviation safety reporting system, Mr. Fontenot, Mr. Guillory, and Mr. Olive serve as an example for all DOI employees to emulate. Their superior performance and significant contributions to aviation safety reflect great credit upon themselves, the Mineral Management Services and the entire Department of the Interior. [SAFECOM 2008-0013](#)

## One of Those Folks Who Just Wants to Know Why



AMD Assoc. Director Mark Bathrick presenting the AirWard to Don Hubbartt

Don Hubbartt is one of those folks who just wants to know why. In this case Don, who works as a lead aircraft attendant at BLM's Ramp Services in Boise and who is a self-made expert in maintaining and repairing the SPH-5 flight helmet, wanted to know why so many of the SPH-5s that he was seeing had cracks in the helmet's shell adjacent to the earcups. Time-after-time field units would send in their helmets to Ramp Services to be inspected and time-after-time approximately 6 out of 10 shells would be cracked; normally in the same area. Since a cracked shell means the helmet is unrepairable, whatever was causing these cracks was costing the Government a lot of money and placing a lot of helmet-wearers at risk.

As Don studied the problem from all angles it occurred to him that he should watch how folks were actually putting the helmets on and taking them off. Don quickly recognized that people were pulling the shells, or the retention assemblies, in order to get their helmets on, and that this action was stressing the shells at the earcups. This action is similar to repeatedly bending a paperclip causing it to break. As a result of Don's discovery, an Interagency Aviation Safety Alert and video were produced to remind folks in the field of the proper donning and doffing procedures for the SPH-5. This information has the potential to drastically reduce the damage to our flight helmets, which in turn will save tens of thousands of dollars, while providing better protection to our aircrews. Thanks Don for seeing a problem, asking why, and not stopping until you uncovered the answer.

## Lights, Camera,...Safety!

AirWards are often associated with acts conducted during actual flying operations such as when a pilot calls it quits when the winds get too squirrely, or when an air attack slows the pace of operations before it gets out of control. However, the description of an AirWard allows this recognition to be bestowed on *"any individual who has demonstrated positive behavior or actions promoting DOI aviation safety."*

Mike Spink's contribution to the DOI Aviation Safety Program is through his exceptional talent as a videographer. During a six week detail to the AMD Training Division Mike has filmed, edited, and produced training videos on Water Ditching and Survival, Aircraft Pre-Use Inspections, and the first ever Interagency Aviation Video Safety Alert. Without Mike's knowledge, skill, and drive, these projects would either be still sitting on the shelf, or would have been done by a commercial source at the cost of many thousands of dollars. Mike's willingness to contribute his time and talent in an effort to improve the interagency aviation safety culture is noteworthy and deserving of recognition.



AMD Assoc. Director Mark Bathrick and Mike Spink

The AMD Aviation Safety and Evaluation and Technical Services Divisions are therefore proud to honor Mike Spink with an AirWard for his exceptional contribution to aviation safety.

## Now you see them...

In early August 2007, Mr. Skip (Harry) Nakashima was working as an AD (administratively determined) Single Engine Air Tanker Manager (SEMG) at the Miles City, Montana, Airport (Eastern Montana Fire Zone Tanker Base). During this period Skip recognized that a number of meteorological evaluation towers in that area of operations posed a significant hazard to low flying helicopters and SEATs. The towers, which are generally less than 200 feet tall, are hard to see because they do not require lighting.



SEMG Skip Nakashima

Skip actively sought out information on the towers, tracing down sources and obtaining maps of these aerial hazards to present to aviation staff and pilots during morning briefings. Skip went the extra mile and his efforts to improve aviation safety were certainly appreciated by pilots and the Eastern Montana Fire Zone staff.

Thanks Skip for a job well done!

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## The Next Best Thing



Pilot Carl Ferguson

In April of 2005, Carl Ferguson expressed his concern for the safety of passengers onboard his aircraft while conducting migratory bird studies. The majority of the flights were (and still are) conducted overwater; Carl was concerned that some of his passengers were unable to benefit from the training he regularly assisted in conducting, A-312, Water Ditching and Survival Training.

He suggested to AMD that even if his passengers were unable to attend the Water Ditching and Survival Training, they at least might gain an advantage in the event of a water landing gone astray by reviewing a card posted in an aircraft. This card would show the

"Seven Steps" to safely egress an aircraft after a water ditching; Carl envisioned a series of pictures accompanied by a short written description of each step. As of 2007, this card was developed and published for use.

Thank you Carl for the great idea!

## Not Your Ordinary Day at the Office

March 7, 2007 was to have been a routine day in an extraordinary environment for Yellowstone National Park employees John Fors and Charlie Fleming. Their day began when they snowmobiled to a remote ranger station in the southwest corner of the Park where they performed routine maintenance including shoveling the snow off of the ranger station's roof.

John was working at one building and went to check in with Charlie, who had been shoveling the snow off another. John found Charlie hanging from the roof, suspended by his safety strap, not breathing and unresponsive. John got Charlie down and immediately began rescue breathing. Once he got Charlie breathing on his own John started radioing for help. Knowing that radio communications in the area is virtually non-existent, John started transmitting in the blind. Eventually John was able to establish contact and requested aerial evacuation for Charlie.

*With no actual aviation training, John selected a safe landing zone and packed it down with his snowmobile.*

With no actual aviation training, John selected a safe landing zone and packed it down with his snowmobile. The medevac helicopter was able to safely land and transported Charlie to a medical facility. John's alertness, quick reaction, and knowledge of what to do and when to do it, made the difference between a tragic outcome and saving a co-worker. Fantastic job, John.

## Dispatchers Initiate Mishap Response Guide

On May 21, 2006, Santa Fe Dispatch did an excellent job of recognizing and coordinating a search and rescue effort of a possible overdue aircraft. Lead 33 responded to an IA on the Santa Fe at 2000 hours and at 2015 hours Lead 33 did not respond to radio calls. Santa Fe Dispatch personnel quickly contacted an airtanker and ground crews assigned to the incident to see if they could make contact or see Lead 33. At 2023 Lead-33 went "red" on AFF indicating lost contact. Santa

Fe Dispatch called New Mexico State Police and started the SAR, as well as immediately making appropriate notification in accordance with the Zone Aviation Incident/Accident response guide. Santa Fe Dispatch stayed calm, acted professionally, and most of all, responded quickly to this situation. Lead 33 had experienced electrical problems and had to shut down the all of the aircraft's radios. Lead 33 phoned SWCC at 2030 and informed them of the situation and that he had landed safely. Hats off to Santa Fe Dispatch for their dedication and commitment to safety.



Left to right: Renee Isackson, Nando Lucero, Dee Gallegos, Amy Bauldauf, Willard Tolman



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