



**The**

**Safety**

**Wire**

**August 2021**

## **“Well, this is stupid,”**

I thought to myself halfway through an afternoon jog around the block. The stupid part wasn't that I was jogging in the afternoon heat and humidity of summer in Florida. It was the fact that I knew there was a thunderstorm headed my way before I left, and I still thought I'd be able to make it back in time before the lightning got too close. With twenty minutes left in the run, I realized that my estimations had been incorrect when the time



between lightning flashes and the sound of thunder dropped to a couple of seconds. To add to how dumb I was being, I've lived in Florida for nearly 20 years and it is the same weather pattern every afternoon here in the summer. In fact, I wrote about the identical scenario back in 2012 after cheating death on an afternoon run where thunderstorms caught me out in the open.

How can the 'safety guy' make the same, basic mistake ten years after announcing to the world how obviously dumb the decision had been? In a word, complacency. Complacency is one of the top concerns listed in every safety survey APSA has conducted over the last 10 years. It tends to be one of those soft targets that we are all aware of, but still are not sure exactly what it means or how to fix it. We tend to be really

good at pointing out complacency in others, while remaining dangerously blind to our own shortcomings until we are provided a painful, or at least embarrassing, reminder. Definitions of complacency vary, but generally contain two main ingredients. First is a feeling of self-satisfaction in one's own performance or abilities. The second part is a simultaneous deficiency in situational awareness of the risks involved in the activity we're involved in.

Of the many forms and causes of complacency, one aspect is the attention we give only to exciting stuff. When something is new, fast paced, fun or a welcome change from whatever we consider normal, it is usually not difficult to study, practice, stay mentally engaged or



just generally pay attention. Complacency grows when we start feeling comfortable with an activity, or worse, bored with it. Sometimes it springs up when the 'exciting' part of our day is over and we let down our guard to breathe a sigh of relief or relax in the satisfaction of a job well done. We may also let our comfort with an activity lead us to believe we don't have to pay attention as much and believing there isn't any harm in sliding out the cell phone or performing some other nonessential activity.

The sad fact of accident reports is that they usually start with normal, unremarkable moments in a person's day instead of any blockbuster, Hollywood-style points in our lives that would be easy to identify. It is when we start feeling comfortable that we need to be vigilant in our training and studies. Complacency is, in many ways, a byproduct of experience. It should be expected and actively countered with routine effort to keep the pointy end of the spear sharp. Over ten years, I'd won the race against so many thunderstorms it had become just a normal part of my summer. I incorrectly credited personal skill. Be suspicious of mindless routine, comfort and boredom, three things far more likely to hurt us than any criminal.

*"The smallest amount of vanity is fatal in aeroplane fighting.  
Self-distrust rather is the quality to which  
many a pilot owes his protracted existence."*

*~ Eddie Rickenbacker  
Top American Ace in WWI*

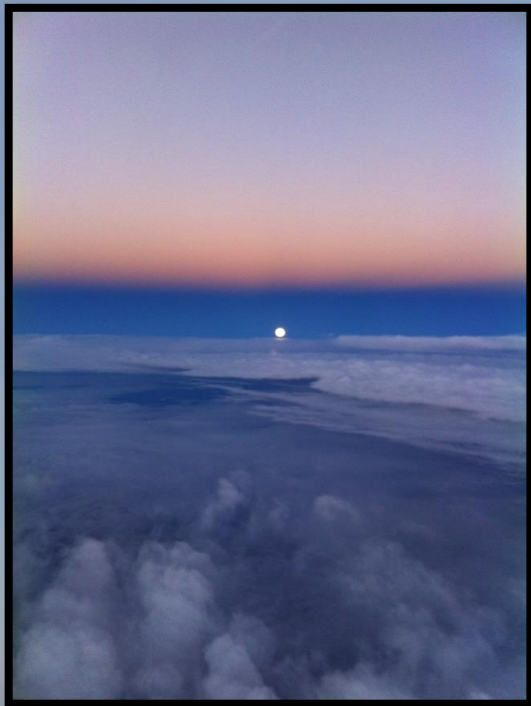
## ONLINE MEETINGS

APSA conducts regularly scheduled online meetings for safety officers, maintenance technicians, SAR personnel, UAS operators and natural resource personnel 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.

If you would like to join, send an email to:

[safety@publicsafetyaviation.org](mailto:safety@publicsafetyaviation.org)

The schedule for upcoming APSA online meetings is as follows.



**UAS:**

Wednesday, Sept 8, 2021  
1:00 PM - 2:00 PM EDT (1700 UTC)

**Safety Officers:**

Friday, Sept 24, 2021  
1:00 PM – 2:00 PM EDT (1700 UTC)

**Natural Resources:**

Wednesday, October 6, 2021  
1:00 PM – 2:00 PM EDT (1700 UTC)

**Maintenance:**

Wednesday, October 13, 2021  
1:00 PM - 2:00 PM EDT (1700 UTC)

**SAR:**

Wednesday, November 3, 2021  
1:00 PM – 2:00 PM EDT (1700 UTC)

*"Coffee tastes better if the latrines are dug downstream from an encampment."*

~ US Army Field Regulations, 1861

## Resources

### Air Support Safety

- <https://store.bookbaby.com/book/AirSupportSafety>
- [https://www.amazon.com/Air-Support-Safety-Airborne-Public/dp/1736706500/ref=sr\\_1\\_1?dchild=1&keywords=Bryan+Smith+flight+support&qid=1626629875&s=books&sr=1-1](https://www.amazon.com/Air-Support-Safety-Airborne-Public/dp/1736706500/ref=sr_1_1?dchild=1&keywords=Bryan+Smith+flight+support&qid=1626629875&s=books&sr=1-1)

### Police Aviation News

- [http://www.policeaviationnews.com/News\\_Archive.htm](http://www.policeaviationnews.com/News_Archive.htm)

### Transport Canada Aviation Safety Letter

- <https://tc.canada.ca/sites/default/files/2021-07/ASL-2-2021.pdf>

### NASA Callback Safety Report Newsletter

- [https://asrs.arc.nasa.gov/publications/callback/cb\\_499.html](https://asrs.arc.nasa.gov/publications/callback/cb_499.html)

## 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.

**Warning light that does not match corresponding gauge  
(i.e., Low Nr, oil pressure or temp, etc.)**

## 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:** AS 350B2  
**Injuries:** 3 minor  
**NTSB#:** CEN11FA359

<https://data.nts.gov/carol-reppen/api/Aviation/ReportMain/GenerateNewestReport/79250/pdf>

The pilot had recently purchased the helicopter and was receiving flight training from a certified flight instructor (CFI). During practice traffic pattern work, the helicopter's hydraulic system was turned off to simulate hydraulic failure on the flight control system. During the approach, the airport's ground controller reported that they were on the wrong radio frequency, so the CFI changed the radio to the correct frequency. The helicopter's airspeed slowed and the helicopter entered an uncommanded left yaw. The CFI tried to regain control by adding right pedal, trying to gain for forward airspeed, and reducing power. The helicopter did not respond to the CFI's control inputs. Subsequently, the helicopter impacted the ground, rolled on to its side, and a postcrash fire ensued.



A postaccident examination of the helicopter revealed no preimpact mechanical malfunctions or failures that would have precluded normal operations. A review of the helicopter's flight manual reveals the note: "Caution, Do not attempt to carry out hover flight or any low speed maneuver without hydraulic pressure assistance. The intensity and direction of the control feedback forces will change rapidly. This will result in excessive pilot workload, poor aircraft control, and possible loss of control." Additionally, one or both

pilots may have been distracted by the incorrect radio frequency. The CFI reportedly had approximately 3,466 total flight hours, and about 789 hours in a Eurocopter AS 350.

**Aircraft: Cessna 172H**

**Injuries: 1 Fatal**

**Swedish Accident Investigation Board report: RL 2009:03e**

[https://www.havkom.se/assets/reports/RL2010\\_03ea.pdf](https://www.havkom.se/assets/reports/RL2010_03ea.pdf)

The pilot intended from the air to search for deer in the vicinity of the airfield. The pilot took off and turned left round the hill that lies to the east of the airfield, thereafter flying in a westerly direction at low speed and at a low height along the side of the brook. When the aircraft was about 400 m north-east of runway 21, witnesses observed that the engine speed increased and the aircraft began to climb. Immediately afterwards the aircraft was seen to turn to the left and continued in a descending turn, after which it impacted at a steep angle with the ground at the edge of the brook.

The pilot was severely injured in the accident. Ambulance personnel arrived at the accident site 16 minutes after the alarm had been given, and the rescue services arrived four minutes later. The ambulance personnel immediately started cardiopulmonary resuscitation, but despite this and expert treatment in hospital the pilot died the same day.

Inspection of the controls and circuit breakers in the cabin showed that the wing flaps were fully down and the indicator on the instrument panel showed 40 degrees down.



The most likely situation was that the pilot had ceased to search for the roe deer and intended to land on runway 21. The witness observations indicate that the aircraft altitude, just before the start of the descending turn, was greater than usual for an aircraft intending to land on runway 21. The intention of the pilot when setting full flap could therefore have been to increase drag so as to achieve a greater rate of descent and come down to a normal approach angle to the

airfield, without the speed being unacceptably high. In connection with lowering the flaps and climbing, however, the speed reduced so far as to come below stalling speed, whereupon the aircraft dropped its left wing and entered a spin. During this turn the aircraft was influenced by an increasing tailwind, which exacerbated the situation.

SHK ([Swedish Transport Agency](#)) thereby considers it likely that the aircraft entered an inadvertent spin and that the height available for recovery from this critical flight situation was insufficient.

SHK's investigation indicates that the pilot was not correctly strapped in with both the lap strap and shoulder strap during the accident flight, having only the lap strap fastened. The skull injuries to the pilot probably came about as the result of a violent impact with the controls on the instrument panel during the collision with the ground. It was assessed that these injuries would have been limited if the pilot had used the shoulder strap.

*There are no new ways to crash an aircraft...  
...but there are new ways to keep them from crashing.*

*Bryan 'Mug' Smith*

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