

Near Miss Briefs

Information based on reports via the Near Miss Reporting Tool.

23389 Subject: Bird strike C-12J.

Description: During landing flare, several birds were seen entering the runway environment. As the aircraft touched down, the crew heard a bird hit the aircraft. After shutting down, airport security showed the crew two birds that were found dead on the runway. The birds' remains appeared consistent with being hit by the aircraft. Two impact points (identified by bird remains) were found on the leading edge of the left outboard wing. No aircraft damage was found. The incident was entered on the aircraft's 2408-13-1. Environmental conditions were day, marginal visual flight rules (VFR).

23404 Subject: Inadvertent discharge of main fire bottle UH-60L.

Description: The A Company maintainer was tasked with replacing the No. 2 squib on the main fire bottle and completed the steps in accordance with WP1457 for removal and up to Step 7 for reinstallation, leaving the battery disconnected and the No. 2 squib electrically disconnected. A work order was then submitted for avionics to complete Step 9 using WP0161 (Note Step 8 was skipped because it did not apply to the series of fire bottle installed). Without the A Company maintainer present, three D Company avionics personnel were used to complete the work order. One read the voltage on the leads to the No. 2 squib; the second was in the pilot's seat, manipulating the ENG EMER OFF/APU Fire T handles and the fire extinguisher (MAIN/RESERVE) switch; and third was sitting in the LH crew chief's seat, reading the steps for WP0161. The fire bottle was discharged on Branch 2 Test, step 3.2.2, Step No. 5.

After a careful analysis, it was determined that Step 1.1.3 of WP0161 was not complied with prior to executing the Branch 2 test. Step 1.1.3 directed the removal of all wires from the main fire bottle because the Branch 2 test required the battery to be reconnected and for the Fire T handles to be pulled in conjunction with fire extinguisher switch movement to the MAIN position. However, during the Branch 2 test, since the No. 1 squib remained electrically connected, it was activated, discharging the contents of the main fire bottle into the auxiliary

power unit (APU) compartment when the APU fire T handle was pulled and the fire extinguisher switch was moved to MAIN.

The incident occurred due to a lack of understanding of WP0161 being performed by avionics personnel, as well as a lack of communication between the A Company maintainer and avionics. The misconfiguration of the main fire bottle for the task being performed should have been identified during the test setup and remedied before the battery was reconnected. Also, it was made clear by avionics that their expectation is for maintainers to disconnect all of the wires on the fire bottle. However, this expectation was not communicated to the A Company maintainer, and WP1457 does not call for the disconnection of all the wires leading to the main fire bottle. Therefore, the No. 1 squib was not disconnected. A face-to-face handoff between the A Company maintainer and the avionics team would have revealed that the No. 1 squib was still connected and confirmed who was going to disconnect it. WP tasks involving hazardous energy should be thoroughly reviewed, critical steps be briefed to personnel involved and verification of the configuration of the aircraft be completed before beginning work.

23885 Subject: Aircraft smoke in cockpit during flight.

Description: While returning to base after a static display, the crew smelled something burning. Not knowing it was, they began to return to base and terminate the mission. During the flight, the smell became stronger and smoke could be seen in the cockpit. The crew referenced the FRC, found a suitable landing area and executed a precautionary landing to a field outside of a local church. After recovery, it was confirmed that during the mission, the lockout zip tie on the circuit breaker of AC CABS system that was uninstalled had fallen off and the breaker pushed in, energizing the system upon startup. No damage occurred to the aircraft.

23957 Subject: Main rotor head gear shaft sling failed during removal of gear shaft.

Description: During installation of the main rotor

gear shaft, the Soldier realized he forgot to show spring underneath the gear shaft to a technical inspector (TI). He attached the gear shaft sling back on the gear shaft and started lifting. When the gear shaft was lifted about 6 inches, one side of sling cable failed and snapped. Two personnel were involved in this event. They were using the correct manual for the maintenance procedure and were licensed on the equipment used. No personnel were injured and no other components were damaged other than the sling.

24016 Subject: UH-72A miscompare in engine torques resulting in a precautionary landing.

Description: During a training flight in a UH-72A and in the traffic pattern, the instructor pilot (IP) induced a simulated SEF in flight, which resulted in a miscompare in engine torques. The torque split caused the IP to diagnose an engine underspeed and conduct a precautionary landing. Inspection by maintenance noted a miscompare in the pilot and co-pilot engine trim positions. The pilot may have inadvertently moved the engine trim switch in the wrong direction while responding to the SEF in flight.

24133 Subject: Damage found to stabilator on postflight inspection of UH-60L.

Description: During an instrument flight rules (IFR) training flight in icing conditions, ice that had accumulated on the tail rotor paddles was shed with the de-icing system. The ice then impacted the right-side upper surface of the stabilator, causing repairable damage to the sheet metal skin surface and one longitudinal rib. The ice was suspected to have shed at some point during the 2 hour flight, but was not found until postflight inspection. The estimated cost of damage was approximately \$2,500.

24197 Subject: Aircraft flown in a "Red X" condition.

Description: An aircrew was conducting a flight for a rated crewmember's pilot in command progression. During the standard flight controls check, it was found that the stabilization augmentation system was "chattering," which is not typical during this check. The crew notified maintenance, and avionics deemed the aircraft to be unsafe for flight via a "Red X" and began troubleshooting. The crew brought the logbook into the maintenance office to begin write-ups for

the repairs and replacements being done. The work was checked by quality control, and a maintenance operational check was annotated as a requirement prior to the next flight. The crew was notified that the required maintenance operational check was to perform another standard flight controls check as annotated in the operator's checklist. The maintenance check was conducted, and the requirement was annotated as complete in the logbook (returning it to a fully mission capable aircraft). It should be noted that the requirement was signed off by an unknown person under another person's login. The flight was conducted with no issues.

The following day, the unit's maintenance test pilot was notified of the "Red X" condition for the first time. The maintenance test pilot notified the unit that the repairs and replacement that had been completed required a significant maintenance check that could only be conducted by a maintenance test pilot. In summary, the appropriate checks were not completed and the aircraft flew with an existing deficiency that was unsafe for flight.

24233 Subject: Refuel truck contacted an aircraft blade.

Description: After performing a cold refueling of an aircraft, the fuel truck operator attempted to drive under the rotor system. The top of the HEMETT hit one of the blades. Inspection of the blade found no damage.

24259 Subject: Shadow landing incident.

Description: The UAS platoon was recovering an RQ-7Bv2. Upon landing, the crew chief called "good touchdown" with "safe landing." Immediately after completing the statement, the Shadow's arresting hook assembly failed upon contact with the arresting line, shearing it into two pieces. The unmanned aircraft continued into the secondary containment net located on the southern side of the runway, coming to a stop with no significant damage. The arresting hook assembly was scheduled to be replaced at the aircraft's 500-hour phase, which was less than 25 hours away. Following the mishap, it was recommended to start the phase early due to the inspections needed to ensure the aircraft was airworthy. Human error or weather were not believed to have been a factor.

24294 Subject: Weapons operational check AH-64D

Description: During a routine weapons operational check on the aircraft, the crew actioned the 30 mm chain cannon with the acquisition fixed forward and the gun moved downward into the ground. The crew followed proper procedures, which normally would not have the 30 mm chain cannon contact the ground. It is suspected that with TESS installed, this can happen by no fault of the crew other than not performing this task while in the air. There was no reported damage to the AH-64D.

24311 Subject: AH-64E FOD

Description: While conducting preventive maintenance, a crew chief left a can of corrosion prevention compounds (CPC) in the catwalk of a

AH-64E helicopter. The can was dangerously close to the flight controls and one of the driveshafts. The aircraft was inspected and signed off by a TI in the unit. The AH-64E was preflighted by two pilots to support a mission later that night. The preflight was conducted at night, which may have contributed to the can being missed. Another possible contributing factor was that the aircraft was preflighted by different pilots than the ones who flew the AH-64E. The aircraft flew for three hours and, fortunately, the can did not shift in flight. The can of CPC was found by a crew chief following the flight while conducting daily maintenance. ■