

ASRS Database Report Set

Rotary Wing Aircraft Flight Crew Reports

Report Set Description.....A sampling of reports from flight crew of rotary wing aircraft.

Update Number.....32.0

Date of UpdateDecember 28, 2017

Number of Records in Report Set.....50

Number of New Records in Report Set46

Type of Records in Report Set.....For each update, new records received at ASRS will displace a like number of the oldest records in the Report Set, with the objective of providing the fifty most recent relevant ASRS Database records. Records within this Report Set have been screened to assure their relevance to the topic.

National Aeronautics and
Space Administration

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TH: 262-7

MEMORANDUM FOR: Recipients of Aviation Safety Reporting System Data

SUBJECT: Data Derived from ASRS Reports

The attached material is furnished pursuant to a request for data from the NASA Aviation Safety Reporting System (ASRS). Recipients of this material are reminded when evaluating these data of the following points.

ASRS reports are submitted voluntarily. The existence in the ASRS database of reports concerning a specific topic cannot, therefore, be used to infer the prevalence of that problem within the National Airspace System.

Information contained in reports submitted to ASRS may be amplified by further contact with the individual who submitted them, but the information provided by the reporter is not investigated further. Such information represents the perspective of the specific individual who is describing their experience and perception of a safety related event.

After preliminary processing, all ASRS reports are de-identified and the identity of the individual who submitted the report is permanently eliminated. All ASRS report processing systems are designed to protect identifying information submitted by reporters; including names, company affiliations, and specific times of incident occurrence. After a report has been de-identified, any verification of information submitted to ASRS would be limited.

The National Aeronautics and Space Administration and its ASRS current contractor, Booz Allen Hamilton, specifically disclaim any responsibility for any interpretation which may be made by others of any material or data furnished by NASA in response to queries of the ASRS database and related materials.

Linda J. Connell

Linda J. Connell, Director
NASA Aviation Safety Reporting System

CAVEAT REGARDING USE OF ASRS DATA

Certain caveats apply to the use of ASRS data. All ASRS reports are voluntarily submitted, and thus cannot be considered a measured random sample of the full population of like events. For example, we receive several thousand altitude deviation reports each year. This number may comprise over half of all the altitude deviations that occur, or it may be just a small fraction of total occurrences.

Moreover, not all pilots, controllers, mechanics, flight attendants, dispatchers or other participants in the aviation system are equally aware of the ASRS or may be equally willing to report. Thus, the data can reflect **reporting biases**. These biases, which are not fully known or measurable, may influence ASRS information. A safety problem such as near midair collisions (NMACs) may appear to be more highly concentrated in area “A” than area “B” simply because the airmen who operate in area “A” are more aware of the ASRS program and more inclined to report should an NMAC occur. Any type of subjective, voluntary reporting will have these limitations related to quantitative statistical analysis.

One thing that can be known from ASRS data is that the number of reports received concerning specific event types represents the **lower measure** of the true number of such events that are occurring. For example, if ASRS receives 881 reports of track deviations in 2010 (this number is purely hypothetical), then it can be known with some certainty that *at least* 881 such events have occurred in 2010. With these statistical limitations in mind, we believe that the **real power** of ASRS data is the **qualitative information** contained in **report narratives**. The pilots, controllers, and others who report tell us about aviation safety incidents and situations in detail – explaining what happened, and more importantly, **why** it happened. Using report narratives effectively requires an extra measure of study, but the knowledge derived is well worth the added effort.

Report Synopses

ACN: 1485944 *(1 of 50)*

Synopsis

Helicopter pilot reported sighting a drone over the Griffith Park Observatory while operating at 600 AGL. The pilot altered his climb to avoid the drone.

ACN: 1482595 *(2 of 50)*

Synopsis

Helicopter pilot reported a NMAC with a UAV shortly after takeoff from a hospital.

ACN: 1481192 *(3 of 50)*

Synopsis

C172 pilot reported a hard landing resulted after he encountered rotor wash from a helicopter operating on the ground near the approach end of the runway.

ACN: 1475130 *(4 of 50)*

Synopsis

Helicopter pilot reported that he flew over another helicopter that was air taxiing after a parallel approach, but was on another frequency.

ACN: 1473503 *(5 of 50)*

Synopsis

R44 Instructor reported a precautionary landing in a field due to power fluctuations.

ACN: 1471845 *(6 of 50)*

Synopsis

Helicopter instructor pilot reported a Near Mid-Air Collision in the traffic pattern due to an aircraft departing in the opposite direction.

ACN: 1471749 *(7 of 50)*

Synopsis

An Air Carrier Captain reported that while on short final, a helicopter was observed sitting on the end of the same runway. The conflict was resolved in time for the aircraft to land safely.

ACN: 1471463 *(8 of 50)*

Synopsis

CRJ-900 First Officer reported a NMAC while on approach as they were too slow to react to a RA from a helicopter.

ACN: 1470462 *(9 of 50)*

Synopsis

HCF Controller reported a problem that might have been caused by FUSION Radar, or the Controller not using the correct procedure.

ACN: 1469156 *(10 of 50)*

Synopsis

GA flight instructor reported taking evasive action from a helicopter as his student departed SCD following a touch and go. The helicopter did not have a radio installed.

ACN: 1466893 *(11 of 50)*

Synopsis

Air Taxi Pilot reported he encountered IMC conditions while on a ferry flight on a VFR flight plan.

ACN: 1464181 *(12 of 50)*

Synopsis

Helicopter pilot reported an encounter with extreme atmospheric heat conditions.

ACN: 1464012 *(13 of 50)*

Synopsis

B737 flight crew reported being cleared to cross CHS Runway 15, but had to stop on the runway after being blocked by a helicopter on the other side. The helicopter taxied onto the runway and took off over the B737.

ACN: 1463696 *(14 of 50)*

Synopsis

An Air Taxi Captain reported encountering two conflicting aircraft. The first TCAS warning indicated "DO NOT CLIMB" and a second aircraft warning "CLIMB", which the First Officer did not follow.

ACN: 1462738 *(15 of 50)*

Synopsis

HCF TRACON trainee reported observing an aircraft deviate from the expected missed approach procedure below the minimum IFR altitude and towards arriving traffic.

ACN: 1462160 *(16 of 50)*

Synopsis

A ground observer reported that helicopters frequently fly very close to the hangars and may be a hazard to persons on the ground.

ACN: 1462122 *(17 of 50)*

Synopsis

Helicopter pilot and two controllers reported a runway incursion at VNY airport. Communication issues were cited as contributing factors.

ACN: 1462026 *(18 of 50)*

Synopsis

CRJ-200 flight crew reported a go-around due to a late approach configuration while they looked for helicopter traffic.

ACN: 1461306 *(19 of 50)*

Synopsis

EC135 helicopter pilot reported entering IMC on a return to base from a transport flight, requested assistance from ATC, and was able to descend on an RNAV approach to VMC and landed successfully.

ACN: 1460375 *(20 of 50)*

Synopsis

CRP TRACON Instructor reported that while instructing the Developmental an aircraft overtook a helicopter on departure resulting in a loss of separation.

ACN: 1456599 *(21 of 50)*

Synopsis

Helicopter pilot reported allowing two professional athletes to hang from the helicopter skids and drop 15 to 20 feet into a pond located on private property.

ACN: 1455836 *(22 of 50)*

Synopsis

ZHU Center controllers reported a computer error that related to aircraft routings.

ACN: 1454663 *(23 of 50)*

Synopsis

A Center Controller reported having to turn an aircraft into an area below the MVA due to a parachute jump aircraft not responding to instructions.

ACN: 1453953 *(24 of 50)*

Synopsis

EC145 helicopter pilot reported an NMAC with a fixed wing aircraft.

ACN: 1453177 *(25 of 50)*

Synopsis

Helicopter pilot reported that a patient, possibly injured while cooking methamphetamine, may not have been properly decontaminated prior to transport.

ACN: 1453000 *(26 of 50)*

Synopsis

Helicopter pilot reported a temporary loss of GPS signal approximately three miles north of CRO.

ACN: 1452718 *(27 of 50)*

Synopsis

Maintenance Technician reported an AS355 helicopter airspeed indicator was replaced with an incorrect unit. The original faulty indicator was reinstalled and the aircraft returned to service without documentation.

ACN: 1452393 *(28 of 50)*

Synopsis

A Tower Controller in Charge reported a helicopter was instructed to land via a taxiway and did not comply with a restriction and overflew an aircraft awaiting takeoff.

ACN: 1452132 *(29 of 50)*

Synopsis

An EC130 helicopter pilot reported he unexpectedly entered IMC after doing a due diligence weather preflight which indicated VMC to his base airport. An IFR clearance was obtained enroute.

ACN: 1451748 *(30 of 50)*

Synopsis

AS-365 Captain reported contact with a van on landing at a hospital helipad.

ACN: 1451607 *(31 of 50)*

Synopsis

DEN Tower Controller attempted to use a new procedure that allowed a helicopter and arriving aircraft to get too close causing the helicopter to take evasive action.

ACN: 1449645 *(32 of 50)*

Synopsis

PCT TRACON and DCA Tower Controllers reported an unsafe situation involving VIP movements.

ACN: 1449330 *(33 of 50)*

Synopsis

AS350 helicopter pilot reported concerns that a photo mission in the vicinity of a power plant might be misinterpreted as a security issue.

ACN: 1448941 *(34 of 50)*

Synopsis

Helicopter flight crew reported a takeoff from a taxiway that may have drifted towards the runway being used by a fixed wing aircraft.

ACN: 1448460 *(35 of 50)*

Synopsis

Helicopter pilot reported a NMAC with an airliner in the vicinity of MLI airport.

ACN: 1447789 *(36 of 50)*

Synopsis

Rescue Helicopter pilot reported a near miss at night with what the crew thought was an accompanying aircraft. In reality was an unidentified aircraft.

ACN: 1447142 *(37 of 50)*

Synopsis

A helicopter pilot and a small aircraft pilot reported a NMAC over the Hudson River.

ACN: 1445520 *(38 of 50)*

Synopsis

Helicopter pilot reported a UAV operator stated he was interfering with his commercial business along a boardwalk.

ACN: 1444875 *(39 of 50)*

Synopsis

SMO Tower Controller and inbound jet pilot reported an airborne conflict between a jet arrival and a helicopter transitioning the area when weather deteriorated.

ACN: 1443795 *(40 of 50)*

Synopsis

Pilot of a small aircraft departing an uncontrolled airport reported a near miss with a helicopter departing at the same time.

ACN: 1442286 *(41 of 50)*

Synopsis

EMB505 Captain reported two separate TCAS RA events while on visual approaches to Runway 19R at CCR.

ACN: 1441548 *(42 of 50)*

Synopsis

SCT TRACON Controller in Charge reported that another Controller was having separation problems with aircraft, was asked if the needed help and Controller denied help. Reporter stated staffing issues and no Supervisor in the area at the time.

ACN: 1441525 *(43 of 50)*

Synopsis

SCT TRACON Instructor reported the Developmental did not transfer communication to the Tower until the aircraft reached an area beneath the MVA.

ACN: 1439974 *(44 of 50)*

Synopsis

P31 TRACON Controller reported an unsafe situation where a jet overtook a helicopter on final.

ACN: 1439512 *(45 of 50)*

Synopsis

Helicopter Captain reported fuel quantity failures on a multi-leg patient flight which was later determined by Maintenance to be caused by contaminated fuel.

ACN: 1439008 *(46 of 50)*

Synopsis

R22 instructor pilot reported that after landing they were asked to meet with Federal officials for busting a TFR.

ACN: 1437354 *(47 of 50)*

Synopsis

C182 pilot reported that during takeoff at a non-towered airport he flew over a helicopter that was at the end of the runway.

ACN: 1435156 *(48 of 50)*

Synopsis

Omaha TRACON Controller reported that an IFR aircraft departed on an IFR clearance without being properly released into the airspace.

ACN: 1433926 *(49 of 50)*

Synopsis

Helicopter pilot reported mistakenly flying into STS Class D airspace due to a GPS accuracy error.

ACN: 1433231 *(50 of 50)*

Synopsis

Bell 407 pilot reported landing as soon as possible after receiving an engine chip light in cruise flight.

Report Narratives

Time / Day

Date : 201709
Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : BUR.Airport
State Reference : CA
Altitude.AGL.Single Value : 600

Environment

Flight Conditions : VMC
Weather Elements / Visibility : Haze / Smoke
Weather Elements / Visibility.Visibility : 6
Light : Daylight

Aircraft

Reference : X
Aircraft Operator : Corporate
Make Model Name : Helicopter
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 91
Flight Plan : None
Mission : Photo Shoot
Flight Phase : Cruise
Route In Use : Direct
Airspace.Class E : SCT

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Corporate
Function.Flight Crew : Single Pilot
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Flight Instructor
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Rotorcraft
Qualification.Flight Crew : Multiengine
ASRS Report Number.Accession Number : 1485944

Events

Anomaly.Conflict : Airborne Conflict
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Took Evasive Action

Assessments

Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

While filming scenic shots of Los Angeles over and around the Griffith Park Observatory, I observed a drone maneuvering in flight well above the observatory and had to maneuver below and close to the observatory to avoid the drone. I went into a hover at 600 AGL south of the Observatory and while climbing, had to abort the climb once again due to drone interference. I have had a number of drone encounters in the past six months and I believe it is only a matter of time until a midair occurs. Helicopters typically fly at 500 AGL and it seems that private drone operators are not respecting that airspace or the drone FARs.

Synopsis

Helicopter pilot reported sighting a drone over the Griffith Park Observatory while operating at 600 AGL. The pilot altered his climb to avoid the drone.

Time / Day

Date : 201709

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 100

Environment

Flight Conditions : VMC

Light : Daylight

Aircraft : 1

Reference : X

ATC / Advisory.CTAF : ZZZ

Aircraft Operator : Air Taxi

Make Model Name : Helicopter

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 135

Mission : Ambulance

Flight Phase : Climb

Airspace.Class G : ZZZ

Aircraft : 2

Reference : Y

Make Model Name : UAV - Unpiloted Aerial Vehicle

Operating Under FAR Part.Other

Flight Phase : Cruise

Airspace.Class G : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Taxi

Function.Flight Crew : Single Pilot

Qualification.Flight Crew : Commercial

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Rotorcraft

ASRS Report Number.Accession Number : 1482595

Human Factors : Situational Awareness

Events

Anomaly.Conflict : NMAC

Detector.Person : Flight Crew

Miss Distance.Horizontal : 0

Miss Distance.Vertical : 25

When Detected : In-flight
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

Near midair [with] a small drone flying one block east of the hospital. Our aircraft was on initial climb out at approximately 65 knots and was climbing from helipad to 2200 MSL. Elevation [at] time of near miss was probably 100-150 feet above helipad which is approximately 1250 MSL. The primary departure path from this helipad is standardized due to close noise sensitive areas and must be protected from drone activities and intrusions due to high flight volume around the hospital. We had to look up through the rotors to keep it in sight as it passed directly over the aircraft by about 25-50 feet. We saw it at the last second and had no time to react.

Ground all private drones. They are going to cause a mishap with a manned aircraft, the regulations for their operation do not provide helicopters with a margin of safety that is acceptable to flight crews who cannot see them because they are too small. The drones also do not have lights or markings that aid in their visual acquisition. They also do not register on TCAS or other radar systems. Alternately, "no drone" fly zones within 1 NM of all hospital helipads.

Synopsis

Helicopter pilot reported a NMAC with a UAV shortly after takeoff from a hospital.

Time / Day

Date : 201709

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : MDQ.Airport

State Reference : AL

Altitude.AGL.Single Value : 200

Environment

Flight Conditions : VMC

Weather Elements / Visibility.Visibility : 20

Light : Daylight

Ceiling.Single Value : 2000

Aircraft : 1

Reference : X

ATC / Advisory.CTAF : MDQ

Aircraft Operator : Personal

Make Model Name : Skyhawk 172/Cutlass 172

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 91

Flight Plan : None

Mission : Personal

Flight Phase : Final Approach

Route In Use : Visual Approach

Airspace.Class G : MDQ

Aircraft : 2

Reference : Y

ATC / Advisory.CTAF : MDQ

Aircraft Operator : Military

Make Model Name : Chinook (CH-47)

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Mission : Ferry

Flight Phase : Taxi

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Personal

Function.Flight Crew : Single Pilot

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Commercial

Experience.Flight Crew.Total : 750

Experience.Flight Crew.Last 90 Days : 5

Experience.Flight Crew.Type : 550
ASRS Report Number.Accession Number : 1481192

Events

Anomaly.Inflight Event / Encounter : Weather / Turbulence
Anomaly.Inflight Event / Encounter : Unstabilized Approach
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Took Evasive Action

Assessments

Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

I was on a final stabilized VFR approach to runway 18 at MDQ and just about to flare when I encountered significant turbulence from a Chinook helicopter, both rotors turning, that was waiting to takeoff from a spot on the grass between the touchdown zone of runway 18 and the parallel taxiway. The turbulence hit me just at about the flare and I was barely able to salvage a very hard landing.

This is an airport that has significant helicopter activity. I believe some airport rules should be considered to restrict this type of helicopter operation near the approach end of the active runway as an effort to eliminate/minimize such turbulence.

Synopsis

C172 pilot reported a hard landing resulted after he encountered rotor wash from a helicopter operating on the ground near the approach end of the runway.

Time / Day

Date : 201708

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : CMA.Airport

State Reference : CA

Altitude.AGL.Single Value : 200

Environment

Flight Conditions : VMC

Weather Elements / Visibility.Visibility : 7

Light : Daylight

Aircraft : 1

Reference : X

ATC / Advisory.Tower : CMA

Aircraft Operator : Corporate

Make Model Name : Helicopter

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 91

Flight Plan : None

Mission : Passenger

Flight Phase : Final Approach

Route In Use : Visual Approach

Airspace.Class D : CMA

Aircraft : 2

Reference : Y

ATC / Advisory.Ground : CMA

Aircraft Operator : Corporate

Make Model Name : Robinson R44

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 91

Flight Plan : None

Mission : Passenger

Flight Phase : Taxi

Route In Use : Visual Approach

Airspace.Class D : CMA

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Corporate

Function.Flight Crew : Single Pilot

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Flight Instructor

Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Flight Engineer
Qualification.Flight Crew : Rotorcraft
Experience.Flight Crew.Total : 10000
Experience.Flight Crew.Last 90 Days : 15
Experience.Flight Crew.Type : 400
ASRS Report Number.Accession Number : 1475130
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : ATC

Events

Anomaly.ATC Issue : All Types
Anomaly.Conflict : NMAC
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : Clearance
Detector.Person : Flight Crew
Miss Distance.Horizontal : 100
Miss Distance.Vertical : 100
When Detected : In-flight

Assessments

Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

I was flying a traffic pattern using runway 26 at CMA. On downwind abeam the tower I was advised of R-44 traffic (2 aircraft) in the pattern and to report them in sight. I did not see the traffic and reported that to the tower. I was instructed to continue and a landing clearance would be issued when I had them in sight. I continued on downwind, then base and upon turning final I saw one R-44 on short final ahead of me and one on a parking spot near the east end of Taxiway G, a short distance from the landing area, with his rotor turning at operating RPM. My assessment was that those two R-44s were the traffic I was advised of in the pattern when I was on downwind. Hence, I reported them in sight and was given a clearance to land. I continued my approach and focused on avoiding the parked R-44s while maneuvering to my parking area. I did not hear any other traffic on the tower frequency at that time. Upon touchdown my ground crew advised that I had overflowed an airborne R-44 maneuvering for parking and my rotor wash had caused the R-44 control problems. I was unaware of the third R-44 until then.

Upon investigation I learned the R-44 that I had flown over had conducted an offset parallel approach approximately 500 feet to my right and was not on tower frequency but on Ground, as was the procedure established by the tower. Upon termination of his approach he proceeded to air taxi to his parking area which crossed my final approach path. Neither one of us were aware of each other. The use of two frequencies for landing traffic to the same area caused a lack of situational awareness and control which could have led to tragic results. This was brought to the attention of the FAA Inspector and the use of two frequencies for controlling traffic was discontinued.

Synopsis

Helicopter pilot reported that he flew over another helicopter that was air taxiing after a parallel approach, but was on another frequency.

Time / Day

Date : 201708

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.MSL.Single Value : 1300

Environment

Flight Conditions : VMC

Light : Daylight

Aircraft

Reference : X

Aircraft Operator : FBO

Make Model Name : Robinson R44

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Flight Plan : None

Mission : Training

Flight Phase : Cruise

Route In Use : None

Airspace.Class G : ZZZ

Component

Aircraft Component : Engine

Aircraft Reference : X

Problem : Malfunctioning

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : FBO

Function.Flight Crew : Instructor

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Rotorcraft

Qualification.Flight Crew : Commercial

Qualification.Flight Crew : Flight Instructor

Qualification.Flight Crew : Instrument

Experience.Flight Crew.Total : 1450

Experience.Flight Crew.Last 90 Days : 90

Experience.Flight Crew.Type : 415

ASRS Report Number.Accession Number : 1473503

Events

Anomaly.Aircraft Equipment Problem : Critical
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Took Evasive Action
Result.Flight Crew : Landed As Precaution

Assessments

Contributing Factors / Situations : Aircraft
Primary Problem : Aircraft

Narrative: 1

While transitioning back to [departure airport], the engine started making a loud banging noise. I scanned the instrument cluster and saw the RPM's surging and manifold pressure spiking. I decided that we could not make it back to [departure airport] and lowered collective and picked a field to land in to check it out. I make an expeditious descent and land with power at the bottom with no other damage to the helicopter. Upon landing I saw white smoke coming from behind us, so I told my student to get out and see if we are on fire as I rapidly shut down the helicopter and pull fuel. There was no fire, just smoke from oil burning on the muffler.

Synopsis

R44 Instructor reported a precautionary landing in a field due to power fluctuations.

Time / Day

Date : 201708

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Relative Position.Distance.Nautical Miles : 2

Altitude.AGL.Single Value : 400

Environment

Flight Conditions : VMC

Weather Elements / Visibility : Haze / Smoke

Weather Elements / Visibility.Visibility : 4

Light : Daylight

Ceiling.Single Value : 12000

Aircraft : 1

Reference : X

ATC / Advisory.CTAF : ZZZ

Aircraft Operator : Personal

Make Model Name : Helicopter

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Flight Plan : None

Mission : Training

Flight Phase : Final Approach

Route In Use : Direct

Airspace.Class G : ZZZ

Aircraft : 2

Reference : Y

ATC / Advisory.CTAF : ZZZ

Make Model Name : Small Aircraft

Operating Under FAR Part : Part 91

Flight Phase : Takeoff

Flight Phase : Initial Climb

Airspace.Class G : ZZZ

Aircraft : 3

Reference : Z

ATC / Advisory.CTAF : ZZZ

Make Model Name : Small Aircraft

Operating Under FAR Part : Part 91

Flight Phase : Initial Approach

Airspace.Class G : ZZZ

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Personal
Function.Flight Crew : Pilot Not Flying
Function.Flight Crew : Instructor
Qualification.Flight Crew : Flight Instructor
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Commercial
Experience.Flight Crew.Total : 645
Experience.Flight Crew.Last 90 Days : 80
Experience.Flight Crew.Type : 645
ASRS Report Number.Accession Number : 1471845
Human Factors : Communication Breakdown
Human Factors : Distraction
Human Factors : Situational Awareness
Human Factors : Time Pressure
Human Factors : Workload
Human Factors : Confusion
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Conflict : NMAC
Detector.Person : Flight Crew
Miss Distance.Horizontal : 400
Miss Distance.Vertical : 200
When Detected : In-flight
Result.Flight Crew : Took Evasive Action

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

On a practice approach for the RNAV into ZZZ, a pilot in Aircraft Y made a radio call he was holding at Runway XY and said please advise if there is traffic in the area. Aircraft Z on an 8 mile final for [Runway] XX, also on the practice approach, made immediately a position report and we did ours right after. We reported a one mile final for Runway XX. My Student was flying under a view limiting device and had no visual reference outside. Visibility was 4 miles, haze and smoke so it was hard to see where that airplane was. When I was scanning for that traffic, he appeared right in front of me, airborne, almost same altitude heading straight toward us. I took the controls of the helicopter immediately and did a steep right turn to avoid a midair collision. I made a radio call and said we all would appreciate if he would make a radio call prior to take off. The pilot in Aircraft Y said he wasn't aware of us and said we never did a radio call. However I talked with the pilot in Aircraft Z behind us and he confirmed our radio calls and knew exactly where we were.

Synopsis

Helicopter instructor pilot reported a Near Mid-Air Collision in the traffic pattern due to an aircraft departing in the opposite direction.

Time / Day

Date : 201708
Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : LGB.Airport
State Reference : CA
Altitude.AGL.Single Value : 0

Aircraft : 1

Reference : X
ATC / Advisory.Tower : LGB
Aircraft Operator : Air Carrier
Make Model Name : Commercial Fixed Wing
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger
Flight Phase : Landing
Airspace.Class D : LGB

Aircraft : 2

Reference : Y
ATC / Advisory.Tower : LGB
Make Model Name : Helicopter
Flight Phase : Takeoff
Airspace.Class D : LGB

Person

Reference : 1
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1471749
Human Factors : Confusion
Human Factors : Distraction
Human Factors : Situational Awareness
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : ATC
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Conflict : Ground Conflict, Less Severe
Anomaly.Deviation - Procedural : Clearance
Anomaly.Ground Incursion : Runway
Detector.Person : Flight Crew

When Detected : In-flight

Result.Flight Crew : Requested ATC Assistance / Clarification

Assessments

Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Procedure

Contributing Factors / Situations : Staffing

Primary Problem : Human Factors

Narrative: 1

KLGB tower had cleared us for landing on RWY 30. There was no mention of a helicopter on the RWY. At approximately 1500 MSL, I asked the FO (First Officer) if it looked like there was something on the RWY around the numbers. It looked like a black spot in the vicinity of the RWY numbers. The FO said it looked like a rubber mark to him. I concurred. At approximately 600 feet MSL, we saw a helicopter rapidly exiting the runway from the RWY number area towards the adjacent TWY D3. He was clear of RWY at 500 feet MSL. We landed. The FO and I discussed afterwards that we BOTH never saw the helicopter! Tower NEVER said anything either! I called the tower chief to discuss. He told me that the controller on duty was working two helicopters mid field, and four other aircraft in the pattern, excluding us. He said that the helicopter was previously cleared to land on the numbers (30). This implied that he was to exit the runway ASAP afterwards to the nearest taxiway as per the AIM. He never did. He said that the controller assumed he had exited. He said he believed the controller was task saturated. Interestingly, the top of the helicopter was painted black. For some reason it completely blended into the runway environment. The tower chief agreed.

Synopsis

An Air Carrier Captain reported that while on short final, a helicopter was observed sitting on the end of the same runway. The conflict was resolved in time for the aircraft to land safely.

Time / Day

Date : 201708

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : LGA.Airport

State Reference : NY

Altitude.MSL.Single Value : 2000

Environment

Flight Conditions : VMC

Light : Daylight

Aircraft : 1

Reference : X

ATC / Advisory.Tower : LGA

Aircraft Operator : Air Carrier

Make Model Name : Regional Jet 900 (CRJ900)

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Initial Approach

Route In Use : Visual Approach

Airspace.Class B : NYC

Aircraft : 2

Reference : Y

ATC / Advisory.TRACON : N90

Make Model Name : Helicopter

Crew Size.Number Of Crew : 1

Flight Phase : Cruise

Airspace.Class B : NYC

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1471463

Human Factors : Communication Breakdown

Human Factors : Confusion

Human Factors : Situational Awareness

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : ATC

Events

Anomaly.Conflict : Airborne Conflict
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Automation : Aircraft TA
Detector.Automation : Aircraft RA
Miss Distance.Vertical : 300
When Detected : In-flight
Result.Flight Crew : Became Reoriented
Result.Flight Crew : Took Evasive Action

Assessments

Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

Going into LaGuardia we had just been vectored onto base for the ILS 22, had called airport in sight, and had been cleared for the visual approach. We had been assigned about a 130 heading prior to being cleared for the visual so I set the heading to approximately 180 to join the LOC at GREKO thus shallow our localizer intercept angle, I also selected approach mode. We were already in a decent to 2000 ft, approaching 3000 ft, and I noted we were high on the glideslope, so I set 1000 ft into the FCP and increased our rate of descent to 1500 FPM. My intention was to descend faster initially till we were closer to the glideslope, then shallow the descent to make sure the glideslope would capture at GREKO, not ALTSCAP at 2000 before GS intercept (GS altitude is 1900 at GREKO). As we descended we got a 'TRAFFIC' TA. Glancing at the map I noted traffic about 1500 ft below us and moving from right to left, and I thought it would be a transitory TA and clear shortly as we passed. The Captain, who was pilot monitoring, then called out something like "you need 1000 FPM". For some reason I mistakenly thought he was referring to the stabilized approach criteria and continued, since I was about to reduce my rate of descent in a few seconds anyway for the glideslope. He repeated himself and I acknowledged and began to spin the vertical speed wheel to reduce the rate of descent. At this point The TA switched to an RA though I don't recall hearing an audible command. Looking at the VSI I saw it was red with a single green line at 0 indicating we needed to level off. It took me a few seconds to process this, move my hand back to the yoke since it had been on the FCP, click off the auto-pilot, and pull back to arrest the descent. At this point according to the display the traffic was 300 ft below us and off to our left, moving away. The Captain called the RA in to tower and I continued to hand fly the rest of the approach, joining the ILS and landing. The traffic turned out to be a helicopter though I do not recall ATC calling them out at any point prior to the TA/RA nor did I ever see the traffic.

The tricky thing about this event was that there were multiple things happening simultaneously. My mind was focused on efficiently joining the approach and not thinking of the possibility of the traffic becoming a conflict, especially since I had not heard the traffic called by ATC. When the SA happened my attention was split between visually flying the approach and looking for traffic, managing the automation, and keeping track of the traffic on TCAS, and trying to decide how best to handle them all at once, which led to a slow reaction. After we landed the Captain said that for a TA you are to reduce your rate of climb/descent to 1000 FPM or less which is what he meant by his call of me needing '1000 FPM' though I don't recall that from training. He may have intended the reduced rate of descent as a command which I interpreted as only a suggestion and thus I didn't react

with as much urgency as I should have. This was also my first time having an actual RA and not simply a TA that resolved itself without any need for action. I think the combination of it being not unusual, especially in busy airspace, to have a TA that resolves itself without any maneuvering combined with all RA's in training being JUST an RA (in other words, you're expecting to deal with an RA, not doing a complicated maneuver and then an TA/RA happens unexpectedly) also contributed to my reactions not being as swift as I would have liked.

Synopsis

CRJ-900 First Officer reported a NMAC while on approach as they were too slow to react to a RA from a helicopter.

Time / Day

Date : 201708
Local Time Of Day : 1801-2400

Place

Locale Reference.ATC Facility : HCF.TRACON
State Reference : HI
Altitude.MSL.Single Value : 1000

Aircraft : 1

Reference : X
Make Model Name : Helicopter
Flight Plan : VFR
Flight Phase : Cruise
Airspace.Class E : HCF

Aircraft : 2

Reference : Y
ATC / Advisory.TRACON : HCF
Make Model Name : Any Unknown or Unlisted Aircraft Manufacturer
Airspace.Class E : HCF

Person

Reference : 1
Location Of Person.Facility : HCF.TRACON
Reporter Organization : Government
Function.Air Traffic Control : Enroute
Qualification.Air Traffic Control : Fully Certified
Experience.Air Traffic Control.Time Certified In Pos 1 (yrs) : 25
ASRS Report Number.Accession Number : 1470462
Human Factors : Distraction
Human Factors : Human-Machine Interface
Human Factors : Situational Awareness
Human Factors : Confusion

Events

Anomaly.Airspace Violation : All Types
Anomaly.ATC Issue : All Types
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Automation : Air Traffic Control
Detector.Person : Air Traffic Control
When Detected : In-flight

Assessments

Contributing Factors / Situations : ATC Equipment / Nav Facility / Buildings
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

I issued a squawk to Aircraft X, was distracted by some departures and conflict alerts to other helicopters in the area. Then noticed the [discrete squawk] code getting close to the towers airspace. The problem is Aircraft X was already tagged up on another non-discrete beacon 1200.

I don't know exactly what happened. I was excited because of the helicopters, Aircraft Y, Aircraft X and two other 1200 codes all in very close proximity to each other and in conflict. I may have accidentally mistagged the 1200 code. But recently we started the fusion program at our facility and was wondering if the fusion tagged the wrong beacon. If this is the case then that would be a big problem.

Synopsis

HCF Controller reported a problem that might have been caused by FUSION Radar, or the Controller not using the correct procedure.

Time / Day

Date : 201707

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : SCD.Airport

State Reference : AL

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC

Weather Elements / Visibility : Haze / Smoke

Weather Elements / Visibility.Visibility : 10

Light : Daylight

Ceiling.Single Value : 2700

Aircraft : 1

Reference : X

ATC / Advisory.CTAF : SCD

Aircraft Operator : FBO

Make Model Name : Small Aircraft, High Wing, 1 Eng, Fixed Gear

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 91

Flight Plan : None

Mission : Training

Flight Phase : Takeoff

Route In Use : Visual Approach

Aircraft : 2

Reference : Y

ATC / Advisory.CTAF : SCD

Aircraft Operator : Corporate

Make Model Name : Helicopter

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 137

Flight Plan : None

Mission : Agriculture

Flight Phase : Cruise

Airspace.Class G : ZTL

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Personal

Function.Flight Crew : Pilot Not Flying

Function.Flight Crew : Instructor

Qualification.Flight Crew : Flight Instructor

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Commercial
Experience.Flight Crew.Total : 560
Experience.Flight Crew.Last 90 Days : 104
Experience.Flight Crew.Type : 520
ASRS Report Number.Accession Number : 1469156
Human Factors : Communication Breakdown
Human Factors : Distraction
Human Factors : Situational Awareness
Human Factors : Time Pressure
Human Factors : Workload
Human Factors : Confusion
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Conflict : Airborne Conflict
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Person : Flight Crew
Miss Distance.Horizontal : 200
Miss Distance.Vertical : 500
When Detected : In-flight
Result.Flight Crew : Took Evasive Action
Result.Flight Crew : Became Reoriented

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Chart Or Publication
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

On short final RWY 27 into SCD to perform a touch and go landing for a commercial pilot training flight, I noticed a clear object rise above the tree line just off the far western end of the runway. Moments prior to touchdown I determined the object I saw was a small bubble canopy helicopter. I had my student continue the landing as the helicopter appeared to be heading westbound, away from us. After touchdown, my student reconfigured the aircraft, applied full power, and initiated a takeoff. At rotation, the helicopter turned from the west to the east, and headed straight down the opposite end of the runway towards us. I briefly considered aborting the takeoff, but was worried that a high speed ground collision between our two aircraft might occur. After rotation, I took the flight controls and continued to climb out at the best rate of climb speed, and sidestepped north, away from the helicopter and runway environment. To my knowledge and from what I saw, the helicopter took no evasive action, and I'm not certain if they even made visual contact with us. Our landing light, taxi light, anti-collision lights, and flashing beacon were all on, and we had been making radio calls on CTAF from at least 10 nm from the airport. The helicopter in question was a small agricultural helicopter, and it had not been making radio calls on SCD CTAF 122.8. Upon arrival back to my home airport, I spoke with the assistant chief flight instructor (and Safety Officer) about the event, and also filed a company safety report. I also called SCD to inquire as to the nature of the helicopter operating on the field without making radio calls. They were operating in the area spraying herbicide on power lines, and also on tree tracts and that their helicopters are not

equipped with radios. I believe this event was caused by the pilot of the aforementioned helicopter failing to exercise proper collision avoidance and scanning techniques, and assuming that a normally quiet airport with low amounts of traffic would automatically be free of any landing traffic. The winds at the time of the event were favoring RWY 27.

In the future, publishing a NOTAM to alert transient aircraft of this non-routine (to SCD) traffic operating in the area could help aid in situational awareness for other pilots operating in the vicinity of the airport. And although not legally required, it would be beneficial for those helicopters to be equipped with radios, so they can more safely coordinate with traffic, and also build a better situational awareness picture for themselves with regards to other aircraft in the area.

Synopsis

GA flight instructor reported taking evasive action from a helicopter as his student departed SCD following a touch and go. The helicopter did not have a radio installed.

Time / Day

Date : 201707

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 500

Environment

Flight Conditions : Marginal

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.TRACON : ZZZ

Aircraft Operator : Air Taxi

Make Model Name : EC135

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 91

Flight Plan : VFR

Mission : Ferry

Flight Phase : Cruise

Airspace.Class G : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Taxi

Function.Flight Crew : Pilot Flying

Function.Flight Crew : Single Pilot

Qualification.Flight Crew : Commercial

ASRS Report Number.Accession Number : 1466893

Events

Anomaly.Conflict : NMAC

Anomaly.Deviation - Procedural : FAR

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Inflight Event / Encounter : Weather / Turbulence

Anomaly.Inflight Event / Encounter : VFR In IMC

Detector.Person : Flight Crew

When Detected : In-flight

Assessments

Contributing Factors / Situations : Weather

Primary Problem : Weather

Narrative: 1

I was sent to the maintenance facility to pick up a spare aircraft and conduct a ferry flight. During my pre-flight planning and weather analysis, I noticed that the METAR at my destination [airport] was reporting MVFR conditions with the TAF forecasting continued MVFR conditions for my expected arrival time. I also noticed pockets of MVFR ceilings along my route of flight. Since I have not received my 297/IFR check yet and I'm a VFR only pilot for now, I decided to file and activate a VFR flight plan for the ferry flight. En route, I encountered a stable deck of MVFR ceilings but the ceilings seemed lower than the 1,500' AGL OVC being reported. There were also scattered clouds at or below 1,000' AGL that I was having to side step and avoid. In addition to the low ceilings, I also encountered several towers that were hard to see in the low light and several crop duster planes doing low-level work at or below 500' AGL estimated. The crop dusters were not communicating on any of the advisory frequencies and I saw one fly underneath me at 200' AGL. I attempted to steer away from the low-flying crop duster but the pilot did a climbing, looping turn and was flying towards me again. I had visual contact with several other low-flying crop dusters but none of the others got as close to me as the first one. As the ceilings continued to drop and push me closer to the ground, I decided to contact TRACON for VFR flight following and radar services. Coms with Approach were weak but they were able to pick me up on radar. I contacted FSS to inquire about the weather at my destination and was told that [the destination] was now reporting IFR and 900' CIG. By that point, I decided to request an IFR pop-up with Approach. Although I have not had my 297 check yet, I feel comfortable flying IFR and maintain my IFR currency flying in the [military].

My decision-making to file IFR en route was in the interest of safety and was impacted by the following, contributing factors:

- 1.) The ceilings en route seemed to be lower than reported
- 2.) I encountered several crop dusters operating low-level in Class G and not communicating with one flying underneath me
- 3.) Some of the towers along my route in the low light and OVC cloud cover
- 4.) Weather at my destination had fallen to IFR conditions
- 5.) I have practiced the [the approach] under VFR conditions and felt comfortable with the IAP
- 6.) At my low altitudes AGL for cloud clearance, I was starting to lose coms with ATC for VFR flight following. I was too far from my home base to talk with my base OPS and I did not feel comfortable not having flight follow coms while "scud running" over unfamiliar airspace.
- 7.) I was conducting a ferry flight with no Passengers under Part 91 [Suggestions] wait for weather to improve along my route of flight and not accept ferry flight missions in the future when there is a high possibility that I may have to request IFR to accomplish the flight.

Synopsis

Air Taxi Pilot reported he encountered IMC conditions while on a ferry flight on a VFR flight plan.

Time / Day

Date : 201707
Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC
Light : Daylight

Aircraft

Reference : X
Aircraft Operator : Air Taxi
Make Model Name : Helicopter
Crew Size.Number Of Crew : 1
Operating Under FAR Part : Part 135
Flight Plan : VFR
Mission : Passenger
Flight Phase : Parked

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Taxi
Function.Flight Crew : Single Pilot
Function.Flight Crew : Pilot Flying
ASRS Report Number.Accession Number : 1464181

Events

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : Weather / Turbulence
Detector.Person : Flight Crew
When Detected : In-flight

Assessments

Contributing Factors / Situations : Weather
Primary Problem : Weather

Narrative: 1

During the [Scenic] Tour I exceeded the flight Envelope Temperature operating limitations of section of the Flight Manual. I was bound by two different limitations, the ZZZ location with 40.36 degree Celsius and ZZZ1 location with 45.74 degree Celsius.

When I arrived for my flight and started prepping for it I was immediately made aware through the Daily Briefing Sheet that the forecasted MAX temperatures will be 40C at ZZZ and 46C at ZZZ1. I knew I will have to constantly pay attention to the actual temperatures for the day.

When I took off from ZZZ1 the temperature was reporting 44C (43.9C actual METAR resolution). Landing at ZZZ the reporting temperature was 38C. At ZZZ the company operations were already shut down but air only tours were still going on since temperature allowed for it. My customers went on to do their tour while I waited approximately 50 minutes. During that time I was paying attention to the temperature at ZZZ which was holding at 39C so I was comfortable taking off at this point. I did briefly look at ZZZ1 which was at 45C. When I got into the aircraft before turning on the engine I listened to the conditions at ZZZ one last time before I committed to the flight and it was still holding at 39C.

This is where my planning was not completed. I should have asked base at ZZZ to confirm for me the ZZZ1 conditions at that instant since my METAR ZZZ1 information was approaching over 20-30 minutes old (45C). In hindsight which I did not confirm at the time they were still below my operating limitations at 45.6C when I was taking off from ZZZ for ZZZ1. If I did confirm this for ZZZ1 before departing ZZZ I would have known that the temperature was trending up and there is a good possibility that temperature would be 46C. The temperature did reach 46C (46.1C) and operations at ZZZ1 were suspended when I came to ZZZ1.

My OAT sensor was still indicating below my limitations but upon coming in for a landing at [the] Ramp the temperature did climb past 46C.

I did not experience any rush or pressure to complete the flight. The cause was my planning and was not seen all the way through since I developed comfort that I will be OK to complete the flight by knowing the immediate temperature for the takeoff and not doing the same for landing (that information was about 20-30 minutes old for me at the time of takeoff at ZZZ).

Synopsis

Helicopter pilot reported an encounter with extreme atmospheric heat conditions.

Time / Day

Date : 201707

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : CHS.Airport

State Reference : SC

Altitude.AGL.Single Value : 0

Environment

Light : Daylight

Aircraft : 1

Reference : X

ATC / Advisory.Ground : CHS

Aircraft Operator : Air Carrier

Make Model Name : B737 Next Generation Undifferentiated

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Taxi

Aircraft : 2

Reference : Y

ATC / Advisory.Tower : CHS

Make Model Name : Helicopter

Crew Size.Number Of Crew : 1

Flight Phase : Taxi

Flight Phase : Initial Climb

Airspace.Class C : CHS

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1464012

Human Factors : Communication Breakdown

Human Factors : Confusion

Communication Breakdown.Party1 : ATC

Communication Breakdown.Party2 : Flight Crew

Person : 2

Reference : 2
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Carrier
Function.Flight Crew : First Officer
Function.Flight Crew : Pilot Not Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1464015
Human Factors : Confusion

Events

Anomaly.ATC Issue : All Types
Anomaly.Deviation - Procedural : Other / Unknown
Detector.Person : Flight Crew
When Detected : Taxi
Result.Flight Crew : Requested ATC Assistance / Clarification
Result.Air Traffic Control : Issued New Clearance

Assessments

Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Ambiguous

Narrative: 1

We pushed back from gate on time and contacted Ground Control for taxi to Runway 21. We were cleared to taxi via Taxiways Bravo, Charlie, Alpha, hold short of Runway 15. We complied with the directions and came to a stop short of the hold short line at Runway 15. As we were waiting, we could see that there was a helicopter on Taxiway A on the north side of Runway 15. After another aircraft departed on Runway 15, Ground Control cleared us to cross Runway 15, taxi to Runway 21 via Alpha. We turned on our exterior lights and began crossing Runway 15. About halfway across the runway, we were able to see that the helicopter was on Alpha facing south, leaving us nowhere to go. We stopped the aircraft on the runway, informed Ground Control that we could not proceed further, and asked for instructions. We were told to "hold position, the helicopter should be departing any second." However, rather than departing from the Taxiway, the helicopter taxied further south to the hold short line southbound on Taxiway Alpha. Again, we asked Ground what was going on, and were told to hold position on Runway 15. The helicopter then taxied onto Runway 15 in front of us, stopping about 50 ft away at our 10 o'clock position facing south into the wind.

The helicopter was on Tower frequency while we were on Ground, so we had no idea what they were doing, and the Ground Controller seemed confused as well. We could not maneuver away, as the helicopter was so close to us that our aircraft exhaust could have caused him damage. After 30 seconds on the runway together, the helicopter suddenly lifted off, just off our left wing, and departed southbound. The entire encounter was marked by confusion on the part of the Ground Controller, who seemed to be unaware of what the helicopter planned to do. The fact that we were on different frequencies on the same piece of pavement at the same time made the entire event very uncomfortable and unsafe. After the helicopter departed, we were cleared to continue taxi via Alpha to Runway 21, and subsequently departed without further incident.

Better coordination between Ground Control and Tower Control is essential. Each aircraft

was on a different frequency and no one seemed to know what the plan was. The helicopter should have departed from the runway, or from the taxiway while we were being held short of 15. The diverse operations at CHS are often challenging, but clear communication of intentions is a must!

Narrative: 2

As we proceeded across Runway 15 (Clear left, clear right, and turning on all exterior lighting) we observed a helicopter on the opposite side of the runway on A. We stopped on Runway 15 as we are blocked from continuing across onto A on the North side. We ask GROUND what to expect. Ground advised us to hold position ON Runway 15 and that he was not certain about the helicopter, and he was on Tower frequency.

After several long and awkward minutes sitting on Runway 15 in the middle of HS1, the helicopter crossed the hold short, proceeded directly to our 10 o'clock position on Runway 15 at very close range, coming to a momentary stop, and in amazement, he rotated and climbed out directly above our left wing. I made clear on Ground frequency that his proximity to us was far too close for our comfort. Ground advised that he would make a report. We continued taxi for a normal departure on Runway 21

It seems to me that the helicopter likely misunderstood his takeoff clearance. There may have been a disconnect between Ground and Tower, but there could be no chance that the helicopter executed his takeoff clearance correctly. When unsure of a clearance, ask for clarification.

Synopsis

B737 flight crew reported being cleared to cross CHS Runway 15, but had to stop on the runway after being blocked by a helicopter on the other side. The helicopter taxied onto the runway and took off over the B737.

Time / Day

Date : 201707

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : LGB.Airport

State Reference : CA

Relative Position.Distance.Nautical Miles : 8

Altitude.MSL.Single Value : 3000

Environment

Flight Conditions : VMC

Weather Elements / Visibility.Visibility : 10

Light : Daylight

Ceiling : CLR

Aircraft : 1

Reference : X

ATC / Advisory.TRACON : SCT

Aircraft Operator : Air Taxi

Make Model Name : Small Transport, Low Wing, 2 Turboprop Eng

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Flight Plan : IFR

Mission : Ferry

Flight Phase : Descent

Route In Use : Vectors

Airspace.Class E : SCT

Aircraft : 2

Reference : Y

ATC / Advisory.TRACON : SCT

Make Model Name : Small Aircraft

Airspace.Class E : SCT

Aircraft : 3

Reference : Z

ATC / Advisory.TRACON : SCT

Make Model Name : Helicopter

Airspace.Class E : SCT

Component

Aircraft Component : Traffic Collision Avoidance System (TCAS)

Aircraft Reference : X

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck
Reporter Organization : Air Taxi
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Not Flying
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Multiengine
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Flight Instructor
Experience.Flight Crew.Total : 8900
Experience.Flight Crew.Last 90 Days : 82
Experience.Flight Crew.Type : 1854
ASRS Report Number.Accession Number : 1463696
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Flight Deck / Cabin / Aircraft Event : Other / Unknown
Anomaly.Conflict : Airborne Conflict
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Automation : Aircraft RA
Detector.Person : Flight Crew
Detector.Person : Air Traffic Control
Miss Distance.Horizontal : 500
Miss Distance.Vertical : 500
When Detected : In-flight
Result.Flight Crew : Became Reoriented
Result.Air Traffic Control : Issued Advisory / Alert
Result.Air Traffic Control : Issued New Clearance

Assessments

Contributing Factors / Situations : Airspace Structure
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

We encountered 2 RA events on a Part 91 reposition/ferry leg to LGB. The pilot flying was receiving type specific instruction.

IFR route clearance was: Fly runway heading, radar vectors, maintain 3000 feet. After level off on assigned altitude of 3000 feet ATC advised us of VFR traffic at 3500 feet at our 11 o'clock. We saw the traffic and I reported the traffic in sight. As we crossed under the single-engine piston airplane we received an RA: 'Do not climb.' We complied.

Shortly thereafter ATC instructed us to descend to 1600 feet. As we approached 2000 feet ATC instructed us to level off at 2000 feet and advised us of another traffic at 1500 feet at our 10 to 11 o'clock. As we leveled off I sighted a helicopter at our 11 o'clock position moving from left to right in level flight 500 feet below us. I reported the traffic in sight and told ATC it's a helicopter. We then received an RA to 'climb, climb.' My copilot maintained level flight. By this time we were crossing above the helicopter and I had the traffic in sight. I determined there was no traffic conflict so did not take over the controls and

allowed my co-pilot to continue flying. The flight concluded with an ILS runway 30 approach to LGB in visual conditions.

During the post flight debrief I clarified to the co-pilot the importance of complying with an RA. He did not know that a TA/RA event takes precedence over ATC instructions. He was also unaware to the requirement to comply with an RA. I will bring this matter to the attention of the training department so these misunderstandings are corrected as soon as possible.

Synopsis

An Air Taxi Captain reported encountering two conflicting aircraft. The first TCAS warning indicated "DO NOT CLIMB" and a second aircraft warning "CLIMB", which the First Officer did not follow.

Time / Day

Date : 201707

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : KOA.Airport

State Reference : HI

Environment

Flight Conditions : VMC

Aircraft

Reference : X

ATC / Advisory.TRACON : HCF

Aircraft Operator : Military

Make Model Name : Helicopter

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Flight Plan : IFR

Mission : Training

Flight Phase : Initial Climb

Route In Use : Direct

Airspace.Class E : HCF

Person

Reference : 1

Location Of Person.Facility : HCF.TRACON

Reporter Organization : Government

Function.Air Traffic Control : Approach

Function.Air Traffic Control : Handoff / Assist

Function.Air Traffic Control : Enroute

Qualification.Air Traffic Control : Developmental

ASRS Report Number.Accession Number : 1462738

Human Factors : Confusion

Human Factors : Training / Qualification

Human Factors : Situational Awareness

Events

Anomaly.ATC Issue : All Types

Anomaly.Conflict : Airborne Conflict

Anomaly.Deviation - Track / Heading : All Types

Anomaly.Deviation - Procedural : Clearance

Anomaly.Inflight Event / Encounter : CFTT / CFIT

Detector.Person : Air Traffic Control

When Detected : In-flight

Result.Flight Crew : Became Reoriented

Result.Flight Crew : Requested ATC Assistance / Clarification

Result.Flight Crew : Executed Go Around / Missed Approach

Result.Air Traffic Control : Provided Assistance

Result.Air Traffic Control : Separated Traffic
Result.Air Traffic Control : Issued New Clearance

Assessments

Contributing Factors / Situations : Airspace Structure
Contributing Factors / Situations : Chart Or Publication
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Chart Or Publication

Narrative: 1

Aircraft X requested one turn in holding at VECKI prior to one practice ILS 17 approach into KOA with the alternate missed approach followed by a clearance to [a different airport]. I was the D-Side so I coordinated the holding at VECKI, ILS 17, followed by the alternate missed approach climbing to 5,000. The holding and approach into KOA were accomplished with no issues. When Aircraft X checked back in with us on the missed approach he was observed making a right hand turn northbound. I notified the R-side and he asked Aircraft X what his intentions were. Aircraft X said he was on the alternate missed approach making a right hand turn to WERAK. WERAK is south of KOA at 174 degree radial 11.8 DME. While Aircraft X was northbound Aircraft Y was cleared for a visual approach Runway 17. Aircraft Z was cleared for a visual approach to follow Aircraft Y. The R-side proceeded to turn Aircraft X southwest bound away from the traffic and obstructions towards the ocean and safety below the Minimum IFR Altitude (MIA). Separation between aircraft was never lost. Aircraft X was clearly confused of what the alternate missed approach procedure entailed. Upon looking at the approach plate, the alternate missed approach is not depicted in the best manner and there is no written description to clarify the diagram.

I would suggest the ILS 17 to KOA approach plate be revised to have a better description of the alternate missed approach procedure. In the diagram, there is nothing showing where the airport is and no written description of the procedure. This could be easily misinterpreted as shown in the event that was shown.

Synopsis

HCF TRACON trainee reported observing an aircraft deviate from the expected missed approach procedure below the minimum IFR altitude and towards arriving traffic.

Time / Day

Date : 201707

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 20

Environment

Weather Elements / Visibility.Visibility : 10

Light : Night

Ceiling.Single Value : 12000

Aircraft

Reference : X

ATC / Advisory.CTAF : ZZZ

Aircraft Operator : Corporate

Make Model Name : Helicopter

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 91

Mission : Passenger

Flight Phase : Final Approach

Airspace.Class E : ZZZ

Person

Reference : 1

Location Of Person : Hangar / Base

Reporter Organization : Personal

Function.Other

Experience.Flight Crew.Total : 300

Experience.Flight Crew.Last 90 Days : 2

ASRS Report Number.Accession Number : 1462160

Human Factors : Situational Awareness

Events

Anomaly.Deviation - Track / Heading : All Types

Anomaly.Deviation - Procedural : FAR

Detector.Person : Observer

When Detected : In-flight

Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors

Primary Problem : Human Factors

Narrative: 1

Tonight a helicopter went over the top of one of my hangars at roughly 20 feet above the roof. I consider this very unsafe especially when there is room in all directions to enter and exit the airport safely without endangering hangars or people. This happens frequently and the pilots do not seem to care. I am worried that one of these helicopter is going to drop through my roof, destroying airplanes and possibly killing people in the hangar. I think most of the problems with helicopters at this airport could be eliminated if they had a set pattern to enter and exit the airport.

Synopsis

A ground observer reported that helicopters frequently fly very close to the hangars and may be a hazard to persons on the ground.

Time / Day

Date : 201707

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : VNY.Airport

State Reference : CA

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.Ground : VNY

ATC / Advisory.Tower : VNY

Aircraft Operator : Corporate

Make Model Name : Helicopter

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Flight Plan : None

Mission : Utility

Flight Phase : Takeoff

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Contracted Service

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Flight Instructor

Qualification.Flight Crew : Commercial

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Rotorcraft

Experience.Flight Crew.Total : 11000

Experience.Flight Crew.Last 90 Days : 55

Experience.Flight Crew.Type : 500

ASRS Report Number.Accession Number : 1462122

Human Factors : Communication Breakdown

Human Factors : Confusion

Communication Breakdown.Party1 : Flight Crew

Communication Breakdown.Party2 : ATC

Analyst Callback : Attempted

Person : 2

Reference : 2

Location Of Person.Facility : VNY.Tower

Reporter Organization : Government
Function.Air Traffic Control : Supervisor / CIC
Qualification.Air Traffic Control : Fully Certified
ASRS Report Number.Accession Number : 1461681
Human Factors : Communication Breakdown
Human Factors : Training / Qualification
Human Factors : Confusion
Communication Breakdown.Party1 : ATC
Communication Breakdown.Party2 : ATC

Person : 3

Reference : 3
Location Of Person.Facility : VNY.Tower
Reporter Organization : Government
Function.Air Traffic Control : Local
Qualification.Air Traffic Control : Fully Certified
ASRS Report Number.Accession Number : 1461685
Human Factors : Training / Qualification
Human Factors : Confusion
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : ATC
Communication Breakdown.Party2 : ATC
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.ATC Issue : All Types
Anomaly.Deviation - Procedural : FAR
Anomaly.Deviation - Procedural : Clearance
Anomaly.Ground Incursion : Runway
Detector.Person : Flight Crew
When Detected : Taxi
Result.Flight Crew : Became Reoriented
Result.Air Traffic Control : Issued New Clearance
Result.Air Traffic Control : Issued Advisory / Alert

Assessments

Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Ambiguous

Narrative: 1

We contacted VNY ground to leave the ramp and taxi to 16L for a southwest departure. Ground cleared us to "taxi via Taxiway B and D for 16L cleared for takeoff". We held short at D and had to ask for frequency change to Tower. Ground advised "contact Tower 119.0". I contacted Tower with request for takeoff 16L for a southwest departure. Tower said "16L cleared for take". I repeated back to Tower what I had heard with no response. We continued out onto 16L. As we began takeoff Tower came on the radio advising "Cessna hold short helicopter is entering runway hold short" then quickly advised "helicopter entering runway the clearance was not for you it was for the Cessna holding short at Taxiway C". Tower then advised us to call the Tower after arrival and shutdown. After departing the airspace copilot had told me that a similar situation had occurred the day prior with a different Captain where ground had cleared them for takeoff on 16L.

This had not been an issue due to no other aircraft involvement in the situation. We contacted tower after we had returned, they took down my information and said I would be contacted if there was any other questions. Later we were departing again from VNY for relocation of the aircraft. We contacted ground again and asked to taxi for departure. Ground came back over the ground frequency and said "taxi to 16L via taxi way B, 16L cleared for takeoff" we repeated back and then proceeded to D and held short. Ground control came back and said "16L cleared for takeoff" we said to ground "confirm 16L cleared for takeoff"? Ground replied with "yes 16L cleared for takeoff". We then replied "we are still on ground do you want us to change frequencies to tower"? Ground control said "yes switch to tower 119.0". We switched to 119.0 and confirmed that we were still cleared for takeoff. Tower replied with "16L cleared for takeoff make left downwind departure to leave the area".

What has caused the most confusion for me and my copilot are.

1. Ground clearance had been saying "16L cleared for takeoff"
2. Copilot had a problem due to tower not keeping a consistent Tower frequency switching from fixed wing frequencies and rotor wing frequencies.
3. The last time I had been to the area we were able to depart direct from our location with a large aircraft and now with large aircraft we are required to ground taxi from the east side of the airport.

Narrative: 2

Helicopter mistook a takeoff departure clearance for a Cessna and departed RWY 16 Left.

I was working CIC and halfway monitoring the local control positions. The Ground controller taxied Helicopter to RWY 16 Left (intersection Delta) as our procedures dictate. I and the Ground Controller were talking about this helicopter and how big it was and how its roterwash is dangerous to especially small aircraft, etc. etc.

I hear the Local controller cross RWY 16 Right with a small Cessna to hold short of RWY 16 Left. My personal thought was why is the Local intentionally putting a C172 that close to a large Helicopter (approx. 900 FT). I heard the Local controller clear someone for takeoff and "a" readback. There was some overlap with another aircraft on frequency. I'm watching this unfold as the Helicopter takes to Rwy 16 Left at delta and depart. The Local Controller starts complaining about "what is this guy doing". The Ground and Helo Positions reached out to the [helicopter] with no response. This is when it occurred to me that the readback was from Helicopter and not the Cessna who had not moved from the hold short position. I shouted to the Local controller that the Helicopter was on his frequency. The Local Controller called [the helicopter] and the pilot responded. The Local Controller then rudely chastised the pilot.

A point that I would like to make now is the poor response of the Local Controller to the situation. Generally we assume the helicopters are ready to depart as soon as they start there 300 ft. taxi clearance to the runway. I confirmed after that "YES" the Local saw the helo at the runway. The Local was attempting to depart the Cessna before the Helo on RWY 16 Left. It was slow motion and as Helo started to taxi onto RWY 16 Left it could have been stopped with a minor runway incursion. I saw that Cessna (that was cleared for Takeoff) wasn't moving. Also the local controller complained (off Freq) about this pilot. This situation with better listening and observations could have prevented it.

Let the Helicopter Position work the Helicopters. The Helo Position can coordinate the use of the runway if needed.

Keep procedures as simple as possible and normal as to what the pilots would expect.

Narrative: 3

I was working LC-1 and LC-2 combined. I had just departed a Lear off 16R. A Cherokee was in the pattern for 16L and I had a release for a Gulfstream with a Cessna awaiting pattern work. In order to allow the gulfstream to depart I crossed over a Cessna to hold short of 16L. I departed the gulfstream first and was waiting a few seconds to depart the Cessna off the parallel for him. GC had passed me a half strip for a helicopter repositioning to depart 16L. I cleared [the Cessna] for left closed traffic off 16L and I did not get a readback since another aircraft keyed up. I asked the other aircraft to identify and there was no response. A few seconds later I did not see the Cessna move to depart and saw the helicopter taking the runway for departure since the gulfstream and helicopter were both large aircraft on departure roll I did not try to cancel either of them but did cancel the Cessna's takeoff clearance. I reached out to see if the helicopter was on frequency and he responded in the affirmative. I told him he had taken the departure clearance of another aircraft and to stand by. I finished making transmissions to the other aircraft in the airspace and then I told the helicopter in more detail what happened to which he admitted full responsibility. I gave him the brasher warning afterwards.

In our SOP we are supposed to give LC-1 a heads up to when a helicopter wants to depart. This was not accomplished. I did not use full length when departing the Cessna because I received the strip late. If GC-1 didn't have such a hard time dealing with the pilot I believe I would have received the strip in time to adhere to the 7110.65 requirement. The CIC was not engaged in the operation and decided to yell at me after the event even though the helicopter admitted it was his mistake. I have asked in previous reports that proper CIC training/refresher is needed at this facility, too many times the operation is being run to the personality of the CIC instead of a standard. The height of the temporary tower creates an angle that is much more difficult to discern the approach end due to the elevation, I may have caught the helicopter quicker if it weren't for this. Also the quality of the binoculars is substandard at this facility to address the poor visibility at the approach end.

Synopsis

Helicopter pilot and two controllers reported a runway incursion at VNY airport. Communication issues were cited as contributing factors.

Time / Day

Date : 201707

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Environment

Flight Conditions : VMC

Light : Daylight

Aircraft : 1

Reference : X

ATC / Advisory.TRACON : ZZZ

Aircraft Operator : Air Carrier

Make Model Name : Regional Jet 200 ER/LR (CRJ200)

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Nav In Use : FMS Or FMC

Flight Phase : Initial Approach

Airspace.Class B : ZZZ

Aircraft : 2

Reference : Y

ATC / Advisory.TRACON : ZZZ

Make Model Name : Helicopter

Airspace.Class B : ZZZ

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1462026

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : First Officer

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1462027

Events

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Conflict : Airborne Conflict
Anomaly.Deviation - Speed : All Types
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : Unstabilized Approach
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Executed Go Around / Missed Approach

Assessments

Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

We were on a visual approach to runway XYZ at ZZZ. We were told to maintain 180 KIAS and contact tower at the FAF. About 2 miles before reaching the FAF, we were configured with only flaps 20 and became distracted by a Traffic Alert that looked very conflicting to our approach path. Once we contacted tower, we were advised of the helicopter traffic that was transitioning, and we finally were able to get a visual on the helicopter. However, I (pilot flying) made no attempt to continue configuring the airplane for landing during that time we were focused on the traffic alert. As we reached 1,000 feet AGL, I asked for the gear down and flaps 30. At 900 feet we were still at slowing from 170 KIAS with the gear still in transition and only flaps 30.

I initiated the go-around and smoothly transitioned into a climb. At this point, tower was instructing us to turn right to a 220 heading and maintain 4,000 feet. I was hand flying (a mistake, in hindsight), and the First Officer (FO) was setting up the Flight Control Panel (FCP) for those parameters, all the while, never announcing a "positive rate" call due to task saturation. At this point I called for the gear up and we were at approximately 200 KIAS with a positive trend vector. Due to the speed, our nose gear did not retract, so it was followed by a "Gear Disagree" warning message. Our speed was approximately 210 KIAS. As soon as we slowed to 200 KIAS, the gear retracted and the message went away.

We then continued back to ZZZ with a normal approach to landing.

The event was primarily caused by a distraction at a critical phase of the approach.

There is one factor that is normal for operations in ZZZ: a high speed assignment with a small window of time allowed to configure prior to 1,000 AGL. The coup de grace was the traffic alert at the most critical part of the approach, and my inattention to flying the airplane, but rather focusing on locating the traffic.

There are two parts to my suggestions for preventing this situation.

First, during the approach, I should have focused on flying, while delegating the FO to look for that traffic, being aware that in ZZZ, you only have about 800 feet to slow from 180 KIAS to and fully configured and final approach speed. Secondly, during the go around, I should have queried the gear up when the FO--who was already task saturated--forgot the

"positive rate" call.

It is my VERY STRONG suggestion for management to change the "positive rate" call to the Pilot Flying (as it used to be). Missing it by a task saturated Pilot Monitoring may have a tendency to snowball into further missed items.

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

CRJ-200 flight crew reported a go-around due to a late approach configuration while they looked for helicopter traffic.

Time / Day

Date : 201707

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Environment

Flight Conditions : Marginal

Light : Dusk

Aircraft

Reference : X

ATC / Advisory.Center : ZZZ

Aircraft Operator : Air Taxi

Make Model Name : EC135

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 135

Flight Plan : IFR

Mission : Ambulance

Flight Phase : Cruise

Airspace.Class E : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Taxi

Function.Flight Crew : Single Pilot

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Instrument

Qualification.Flight Crew : Rotorcraft

Qualification.Flight Crew : Commercial

ASRS Report Number.Accession Number : 1461306

Human Factors : Situational Awareness

Events

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Inflight Event / Encounter : Weather / Turbulence

Anomaly.Inflight Event / Encounter : VFR In IMC

Detector.Person : Flight Crew

When Detected : In-flight

Result.Flight Crew : Requested ATC Assistance / Clarification

Assessments

Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Weather
Primary Problem : Human Factors

Narrative: 1

While enroute back to base from an interfacility transport the crew decision was to abort the flight and return to airport. While executing the 180 degree left turn, aircraft began to enter a low cloud along the ridge line. Pilot decided that continuing the turn could possibly result in an IMC encounter while in a left hand bank. Prior to entering obscuration pilot leveled the aircraft and accepted the IMC event. Pilot announced IMC to crew and proceeded with the IMC emergency procedures for IMC event. Medic in left seat assisted pilot with the IMC cards and approach plates. Upon reaching a VFR on top altitude pilot elected to level off and be prepared to set up for the RNAV approach to base airport. During this time, Pilot, once aircraft control was well established (NON IFR aircraft/No Auto Pilot or HELISAS or MFDs), attempted contact with ATC. Pilot was unable to clearly receive ATC so pilot made call in the blind. Shortly after Pilot was able to receive ATC. Aircraft was configured for IFR flight and approach to base selected and activated. Pilot was following GPS guidance for the RNAV approach about the same time ATC provided heading and other clearance aircraft entered VMC conditions in vicinity of airport. Pilot notified ATC of encountering VMC conditions, and descended within VMC and flew VFR to airport. Upon landing crew debriefed the event and discussed anything we could have done better or improved upon as well as those things we did well. Operations was aware at all times of the status of the flight.

Make the decision to abort as early as possible, do not hesitate.

Synopsis

EC135 helicopter pilot reported entering IMC on a return to base from a transport flight, requested assistance from ATC, and was able to descend on an RNAV approach to VMC and landed successfully.

Time / Day

Date : 201706
Local Time Of Day : 0001-0600

Place

Locale Reference.ATC Facility : CRP.TRACON
State Reference : TX
Altitude.MSL.Single Value : 3000

Aircraft : 1

Reference : X
ATC / Advisory.TRACON : CRP
Make Model Name : Bell Helicopter Textron Undifferentiated or Other Model
Flight Phase : Initial Climb
Route In Use : Vectors
Airspace.Class C : CRP

Aircraft : 2

Reference : Y
ATC / Advisory.TRACON : CRP
Make Model Name : Small Aircraft, Low Wing, 1 Eng, Retractable Gear
Crew Size.Number Of Crew : 1
Flight Phase : Initial Climb
Route In Use : Vectors
Airspace.Class C : CRP

Person

Reference : 1
Location Of Person.Facility : CRP.TRACON
Reporter Organization : Government
Function.Air Traffic Control : Instructor
Function.Air Traffic Control : Approach
Qualification.Air Traffic Control : Fully Certified
Experience.Air Traffic Control.Time Certified In Pos 1 (yrs) : 10
ASRS Report Number.Accession Number : 1460375
Human Factors : Training / Qualification
Human Factors : Distraction

Events

Anomaly.ATC Issue : All Types
Anomaly.Conflict : Airborne Conflict
Anomaly.Deviation - Altitude : Excursion From Assigned Altitude
Anomaly.Deviation - Speed : All Types
Anomaly.Deviation - Track / Heading : All Types
Anomaly.Deviation - Procedural : Clearance
Result.Air Traffic Control : Issued New Clearance

Assessments

Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

I was training a developmental on low east. Runway 31 in use. The developmental had released Aircraft X off the seawall and turned the aircraft north bound after departure. (350 heading) which is the heading needed in accordance with the sop. Aircraft Y departed off runway 31 with a Letter of Agreement (LOA) climbout of Runway heading to 2.5 DME the turn right heading 040 at 016 MSL.

The developmental did not recognize the speed was such an aggressive overtake by Aircraft Y and climbed Aircraft Y to 040 MSL. I brought it to the developmental attention and he turned Aircraft Y to 130 heading to go behind Aircraft X and stopped Aircraft Y's climb to 030 MSL. (Should've stopped Aircraft Y at 020 MSL.)

I was unable to see the altitude of Aircraft X due to overlapping data tags, due to multiple flights working in an area directly above NGP between 065 and 085 MSL. I thought we would have 3miles or divergence but apparently we didn't.

Without taking over every time a developmental makes a bad call, it's difficult to allow someone to learn how to work traffic. I should have stepped in and stopped Aircraft Y at 020 MSL, there were several conversations about Aircraft X prior to this occurrence that prevented insufficient separation with other traffic, with the airspace we have north west of NGP that was the only out. At 5 DME northwest of NGP, Low East (LE) only owns up to 016 MSL so any turns north or west must be pointed out to north radar.

Synopsis

CRP TRACON Instructor reported that while instructing the Developmental an aircraft overtook a helicopter on departure resulting in a loss of separation.

Time / Day

Date : 201706

Local Time Of Day : 1201-1800

Place

Altitude.AGL.Single Value : 20

Environment

Flight Conditions : VMC

Weather Elements / Visibility.Visibility : 10

Light : Daylight

Aircraft

Reference : X

Aircraft Operator : Personal

Make Model Name : Helicopter

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 91

Flight Plan : None

Mission : Personal

Airspace.Class G : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Personal

Function.Flight Crew : Pilot Flying

Function.Flight Crew : Single Pilot

Qualification.Flight Crew : Flight Instructor

Qualification.Flight Crew : Commercial

Experience.Flight Crew.Total : 728

Experience.Flight Crew.Last 90 Days : 150

Experience.Flight Crew.Type : 485

ASRS Report Number.Accession Number : 1456599

Events

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Deviation - Procedural : FAR

Detector.Person : Flight Crew

When Detected : In-flight

Assessments

Contributing Factors / Situations : Human Factors

Primary Problem : Human Factors

Narrative: 1

I was located on private property and was asked to allow 2 passengers to hang from the skids of the helicopter and drop in to a pond of water that was approximately 30 feet deep. I have flown skydivers before and thought, to the best of my ability, that I wasn't violating any regulations at the time and that proper arrangements were in place to keep the action fun, but as safe as possible. The exit technique was the same, the only difference was they were just dropping from 15-20 feet in to a large private pond compared to 6,000 ft with a parachute. It was a closed event, the two jumpers were professional athletes, and we spent 30 minutes on the ground before the stunt reviewing coordination between myself and the two jumpers and proper safety techniques and different scenarios. Additionally, I had standby personnel on site for the jump including a trained lifeguard ready to take action if need be once the two jumpers were in the water. There was absolutely no alcohol involved, weather conditions were perfect and low winds, and the intent was to do something fun while pushing the boundary just a bit to what has been done before.

Looking back, I've made my career as a commercial pilot and instructor by teaching people how to operate the aircraft within the boundaries and realize that the stunt was not probably the safest thing- Risk not worth the reward. I teach my students that good pilots are good decision makers, and I might've allowed my personal boundary to be pushed too far in this case. I also recognize that I was familiar with the technique, had professional athletes, safety crews on standby, and the operation went without a hitch and both jumpers had fun and were perfectly safe. I believe that this might've been too much assumed risk and that I might've violated a regulation by not ensuring that they were wearing seat belts during the take-off. I also can see where, in the incorrect context, it seemed reckless and that the risk might've been too high without more protocol in place. I have learned from this experience, and would like to move forward developing as a pilot. Even though this stunt went flawlessly, I understand that there is a lot to learn and I will not allow my boundaries as a pilot and responsible person to be pushed to doing something that might cause undue risk to people that are involved.

Synopsis

Helicopter pilot reported allowing two professional athletes to hang from the helicopter skids and drop 15 to 20 feet into a pond located on private property.

Time / Day

Date : 201606

Local Time Of Day : 0601-1200

Place

Locale Reference.ATC Facility : ZHU.ARTCC

State Reference : TX

Environment

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.Center : ZHU

Aircraft Operator : Corporate

Make Model Name : Helicopter

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 91

Flight Plan : IFR

Mission : Passenger

Flight Phase : Initial Climb

Route In Use : None

Airspace.Class G : ZHU

Person : 1

Reference : 1

Location Of Person.Facility : ZHU.ARTCC

Reporter Organization : Government

Function.Air Traffic Control : Enroute

Function.Air Traffic Control : Instructor

Qualification.Air Traffic Control : Fully Certified

Experience.Air Traffic Control.Time Certified In Pos 1 (yrs) : 2.5

ASRS Report Number.Accession Number : 1455836

Human Factors : Communication Breakdown

Human Factors : Confusion

Human Factors : Distraction

Human Factors : Situational Awareness

Human Factors : Training / Qualification

Human Factors : Troubleshooting

Human Factors : Human-Machine Interface

Communication Breakdown.Party1 : ATC

Communication Breakdown.Party2 : Other

Person : 2

Reference : 2

Location Of Person.Facility : ZHU.ARTCC

Reporter Organization : Government

Function.Air Traffic Control : Enroute

Function.Air Traffic Control : Trainee

Qualification.Air Traffic Control : Developmental
ASRS Report Number.Accession Number : 455837
Human Factors : Communication Breakdown
Human Factors : Confusion
Human Factors : Distraction
Human Factors : Human-Machine Interface
Human Factors : Training / Qualification
Human Factors : Troubleshooting
Human Factors : Situational Awareness
Communication Breakdown.Party1 : ATC
Communication Breakdown.Party2 : Other

Events

Anomaly.ATC Issue : All Types
Anomaly.Deviation - Procedural : Clearance
Detector.Person : Air Traffic Control

Assessments

Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

I was training in the offshore Central and East positions D side. Traffic was moderate with very little weather in the area with minimal impact. Aircraft X called requesting departure clearance off [an oil rig] to ZZZ. Trainee cleared aircraft via "as filed" climbing to 3000. The trainee started track of the aircraft at the lat/long filed. Shortly after Aircraft Y called looking for a clearance to ZZZ. The trainee ran a route line on Aircraft Y to see his departure position on the scope. This is a common practice to run a route line to see the departure point fast. The trainee cleared the aircraft via "as filed" climbing to 3000.

After the clearance was issued and read back correctly, the trainee got off the line and started a track for the aircraft at the coordinates filed. The track started 115 miles south of what the route line showed where the aircraft should depart and approximately 11 miles near the track of the previously cleared aircraft. I noticed this right away and made sure he checked the CID's (Computer Identification) of the aircraft as they were similar 060 and 068, maybe he mistyped. So he ran a route line on 060 which showed him 115 miles north, he retyped the track at the appropriate coordinates and again it tagged up 115 miles south. So, I had him run a route line on 068 and it showed him 115 miles north and again restarted the track at the appropriate coordinates and it tracked up 115 miles south. Immediately the computer error is recognized and I, the trainer, immediately made a call to [Company] operations to cancel the clearance. The speed dial line listed at both offshore and ocean positions did not work and we were unable to reach [Company] operations timely enough as the aircraft immediately departed both within 11 miles of each other. Both aircraft were radar identified and proceeded on course without further incident.

This appears to be computer/systematic issue as I have never seen a route entry not correlate with the appropriate filed coordinates as they did. These [aircraft] depart every day, all day long without ever seeing a repeat of this prior, I am unsure if there is a recommended change needed other than fixing the issue in our system that caused the difference in route displayed and what was filed.

The [Company] operations line needs to be checked to ensure it is updated with the appropriate dial number or it needs to be fixed so we can immediately reach [Company] operations when needed.

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

ZHU Center controllers reported a computer error that related to aircraft routings.

Time / Day

Date : 201706
Local Time Of Day : 1201-1800

Place

Locale Reference.ATC Facility : ZSU.ARTCC
State Reference : PR
Altitude.MSL.Single Value : 3000

Environment

Flight Conditions : VMC
Light : Daylight

Aircraft : 1

Reference : X
ATC / Advisory.Center : ZSU
Make Model Name : Helicopter
Flight Plan : IFR
Flight Phase : Cruise
Airspace.Class E : ZSU

Aircraft : 2

ATC / Advisory.Center : ZSU
Make Model Name : Small Aircraft, High Wing, 1 Eng, Fixed Gear
Crew Size.Number Of Crew : 1
Operating Under FAR Part : Part 119
Flight Plan : VFR
Mission : Skydiving
Flight Phase : Climb
Route In Use : None
Route In Use : VFR Route
Airspace.Class E : ZSU

Person

Reference : 1
Location Of Person.Facility : ZSU.ARTCC
Reporter Organization : Government
Function.Air Traffic Control : Enroute
Qualification.Air Traffic Control : Fully Certified
Experience.Air Traffic Control.Time Certified In Pos 1 (yrs) : 10
ASRS Report Number.Accession Number : 1454663
Human Factors : Communication Breakdown
Human Factors : Situational Awareness
Human Factors : Confusion
Communication Breakdown.Party1 : ATC
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Airspace Violation : All Types
Anomaly.ATC Issue : All Types
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : CFTT / CFIT
Detector.Person : Air Traffic Control
When Detected : In-flight
Result.General : Flight Cancelled / Delayed
Result.Air Traffic Control : Issued Advisory / Alert
Result.Air Traffic Control : Issued New Clearance

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Airspace Structure
Contributing Factors / Situations : Chart Or Publication
Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Aircraft

Narrative: 1

Aircraft X was a helicopter eastbound on an airway. ZSU has a jump zone for paradrrops on the airway and on the edge of an enroute sector and an approach sector. The Minimum Enroute Altitude (MEA) on the airway is 3,000 feet and off the airway is 3,600 feet inside enroute airspace west of the jump zone. As aircraft X is nearing the eastern boundary of my sector and the western boundary of the approach sector (approximately 8 miles) the Approach Controller calls me for a point out on aircraft Y climbing for paradrrops. I advised the controller to hold the jump aircraft because of the helicopter approaching from the west. The helicopter was in hand-off mode. The Approach Controller called me back to advise that aircraft Y was not responding and turn the helicopter north. I had to turn the helicopter 50 degrees north, off the airway to avoid the jump zone, in a MVA of 3,600 feet. I did ask the pilot to maintain terrain and obstruction clearance.

Send this to the local safety council for analysis. I could have called the Approach Controller in advance to give them a heads up of the traffic on the airway approaching their sector from the east. I talked to the Approach Controller after the close call and he said the pilot never acknowledged the calls, only calling back to report that they were descending. The pilot never gave a "jumpers away" call or "2 minutes to jumpers".

Synopsis

A Center Controller reported having to turn an aircraft into an area below the MVA due to a parachute jump aircraft not responding to instructions.

Time / Day

Date : 201706
Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.MSL.Single Value : 1100

Environment

Weather Elements / Visibility.Visibility : 10
Ceiling.Single Value : 24000

Aircraft : 1

Reference : X
ATC / Advisory.CTAF : ZZZ
Aircraft Operator : Air Taxi
Make Model Name : EC145
Crew Size.Number Of Crew : 1
Operating Under FAR Part : Part 135
Flight Plan : VFR
Mission : Passenger
Flight Phase : Initial Climb
Route In Use : Direct
Airspace.Class E : ZZZ

Aircraft : 2

Reference : Y
ATC / Advisory.CTAF : ZZZ
Make Model Name : Any Unknown or Unlisted Aircraft Manufacturer
Airspace.Class E : ZZZ

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Air Taxi
Function.Flight Crew : Pilot Flying
Function.Flight Crew : Single Pilot
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Private
Experience.Flight Crew.Total : 2530
Experience.Flight Crew.Last 90 Days : 27
Experience.Flight Crew.Type : 30
ASRS Report Number.Accession Number : 1453953
Human Factors : Situational Awareness

Events

Anomaly.Conflict : NMAC
Detector.Automation : Aircraft TA
Detector.Person : Flight Crew
Miss Distance.Horizontal : 300
Miss Distance.Vertical : 100
When Detected : In-flight
Result.Flight Crew : Took Evasive Action

Assessments

Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

While performing Helicopter Emergency Medical Services (HEMS) operations at a hospital, I lifted from the hospital helipad to return to home base. The hospital helipad sits virtually equidistant between [two] airports. Both airports operate on separate Unicom frequencies, but are only 11 NM apart. Considering [one of the airports] to be closer I made a Unicom takeoff call on [their frequency] as well as with company dispatch radio, all the while monitoring [the other frequency] on the 3rd radio for any traffic making calls, none were heard on [the second frequency]. On initial climb from hospital (with no response to Unicom call on [either frequency]), TCAS sounded a proximity alarm and a low flying east-bound fixed wing was spotted approaching from my 9 o'clock at the same altitude. Evasive maneuvers were performed by both aircraft and collision was avoided. I then resumed my climb and northwest flight and landed uneventfully at base.

Synopsis

EC145 helicopter pilot reported an NMAC with a fixed wing aircraft.

Time / Day

Date : 201705

Local Time Of Day : 0601-1200

Environment

Flight Conditions : VMC

Light : Daylight

Aircraft

Reference : X

Aircraft Operator : Air Taxi

Make Model Name : Helicopter

Operating Under FAR Part : Part 135

Flight Plan : IFR

Mission : Ambulance

Flight Phase : Cruise

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Taxi

Function.Flight Crew : Pilot Flying

Function.Flight Crew : Captain

Qualification.Flight Crew : Commercial

ASRS Report Number.Accession Number : 1453177

Human Factors : Communication Breakdown

Human Factors : Training / Qualification

Events

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Deviation - Procedural : Hazardous Material Violation

Detector.Person : Flight Crew

Were Passengers Involved In Event : Y

When Detected : In-flight

Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Company Policy

Contributing Factors / Situations : Procedure

Primary Problem : Procedure

Narrative: 1

During patient transport, hospital staff advised crew that patient had been burned in a butane explosion and was possibly cooking methamphetamine. I was advised by the medical crew that the patient was decontaminated by hospital staff. After flight, aircraft, equipment and personnel were further decontaminated. At no time did the crew smell or believe contaminant was still present. The decontamination after the flight was done out of

an exercise of caution and not [because] of any chemical discovery. After the flight, during a clinical review of the medical patient record, the Medical Director further interviewed the crew and determined that a complete decontamination was most likely not completed. This leads me to believe that there is a possibility that Hazardous Material may have been on the patient during transport.

Synopsis

Helicopter pilot reported that a patient, possibly injured while cooking methamphetamine, may not have been properly decontaminated prior to transport.

Time / Day

Date : 201705

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : CRQ.Airport

State Reference : CA

Relative Position.Angle.Radial : 340

Relative Position.Distance.Nautical Miles : 3

Altitude.MSL.Single Value : 1100

Environment

Flight Conditions : Mixed

Weather Elements / Visibility.Visibility : 8

Light : Daylight

Ceiling.Single Value : 1300

Aircraft

Reference : X

Make Model Name : Helicopter

Crew Size.Number Of Crew : 1

Flight Plan : None

Flight Phase : Cruise

Route In Use : Direct

Airspace.Class E : SCT

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Function.Flight Crew : Pilot Flying

Function.Flight Crew : Single Pilot

Qualification.Flight Crew : Rotorcraft

Qualification.Flight Crew : Air Transport Pilot (ATP)

Qualification.Flight Crew : Flight Instructor

Qualification.Flight Crew : Instrument

Experience.Flight Crew.Total : 4000

Experience.Flight Crew.Last 90 Days : 65

Experience.Flight Crew.Type : 900

ASRS Report Number.Accession Number : 1453000

Events

Anomaly.Aircraft Equipment Problem : Less Severe

Detector.Person : Flight Crew

When Detected : In-flight

Result.Aircraft : Equipment Problem Dissipated

Assessments

Contributing Factors / Situations : Aircraft

Contributing Factors / Situations : ATC Equipment / Nav Facility / Buildings

Primary Problem : ATC Equipment / Nav Facility / Buildings

Narrative: 1

Loss of GPS reception on both GPS units (Garmin 530/430) approximately 3 miles north of CRQ. I had just departed from a helipad and was heading south for the mid field transition at 1100 MSL. Loss of reception occurred and units reacquired signal in a few minutes with no other occurrences.

Synopsis

Helicopter pilot reported a temporary loss of GPS signal approximately three miles north of CRQ.

Time / Day

Date : 201705
Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Altitude.AGL.Single Value : 0

Environment

Light : Daylight

Aircraft

Reference : X
Aircraft Operator : Air Taxi
Make Model Name : AS 355 Twinstar
Crew Size.Number Of Crew : 1
Operating Under FAR Part : Part 135
Mission : Ambulance
Flight Phase : Parked
Maintenance Status.Maintenance Deferred : Y
Maintenance Status.Records Complete : N
Maintenance Status.Released For Service : Y
Maintenance Status.Required / Correct Doc On Board : N
Maintenance Status.Maintenance Type : Unscheduled Maintenance
Maintenance Status.Maintenance Items Involved : Testing
Maintenance Status.Maintenance Items Involved : Inspection

Component

Aircraft Component : Airspeed Indicator
Aircraft Reference : X
Problem : Malfunctioning

Person

Reference : 1
Location Of Person : Hangar / Base
Reporter Organization : Air Taxi
Function.Maintenance : Lead Technician
Qualification.Maintenance : Inspection Authority
Experience.Maintenance.Lead Technician : 20
ASRS Report Number.Accession Number : 1452718
Human Factors : Troubleshooting

Events

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : Maintenance
Anomaly.Deviation - Procedural : FAR

Detector.Person : Maintenance
When Detected : Routine Inspection
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Incorrect / Not Installed / Unavailable Part
Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

During a 91.411/.413 test, it was found the aircraft airspeed indicator (ASI) was faulty with a major case leak. A technician took a repaired ASI unit from the parts room and installed it. The aircraft was then put back in service with no work order or log entry of the instrument change. Later that day, a pilot informed me that the airspeed range markings were incorrect. I verified this and removed the aircraft from service. Our chief pilot, Director of Maintenance (DOM) and operations were informed that the aircraft was out of service. A replacement part was then ordered by the DOM. The aircraft remained out of service for the duration of the week. Upon my return [8 days later], I noticed the aircraft's flight record container was missing from the maintenance shop. I then found the airspeed indicator with the wrong range markings on a technician's tool box. The old faulty airspeed indicator had been reinstalled and the aircraft was back in service. There was no work order or log entry for any of the above maintenance including any post installation system checks. The aircraft is currently in service with a faulty airspeed indicator.

This action does not follow procedures in the repair station manual for proper return to service record completion, replacement of faulty components and does not comply with established FAR part 43 and manufactures system leakage limits. The aircraft is a light twin helicopter and is used as a part 135 passenger transport/air ambulance. Management seems indifferent to the possibility of a certificate suspension and fines due to improper service and maintenance records.

Synopsis

Maintenance Technician reported an AS355 helicopter airspeed indicator was replaced with an incorrect unit. The original faulty indicator was reinstalled and the aircraft returned to service without documentation.

Time / Day

Date : 201705
Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : PAO.Airport
State Reference : CA
Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC
Light : Daylight

Aircraft : 1

Reference : X
ATC / Advisory.Tower : PAO
Make Model Name : Helicopter
Crew Size.Number Of Crew : 1
Mission : Passenger
Flight Phase : Final Approach
Route In Use : None
Airspace.Class D : PAO

Aircraft : 2

Reference : Y
ATC / Advisory.Tower : PAO
Make Model Name : Small Transport, Low Wing, 2 Turboprop Eng
Crew Size.Number Of Crew : 2
Flight Plan : VFR
Nav In Use : GPS
Flight Phase : Landing
Route In Use : None
Airspace.Class D : PAO

Aircraft : 3

Reference : Z
ATC / Advisory.Tower : PAO
Make Model Name : Cessna Aircraft Undifferentiated or Other Model
Crew Size.Number Of Crew : 1
Flight Phase : Taxi
Airspace.Class D : PAO

Person

Reference : 1
Location Of Person.Facility : PAO.TOWER
Reporter Organization : Government
Function.Air Traffic Control : Supervisor / CIC
Qualification.Air Traffic Control : Fully Certified

Experience.Air Traffic Control.Time Certified In Pos 1 (yrs) : 4.0
ASRS Report Number.Accession Number : 1452393
Human Factors : Situational Awareness
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : ATC
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.ATC Issue : All Types
Anomaly.Conflict : Ground Conflict, Less Severe
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : Clearance
Detector.Person : Air Traffic Control
When Detected : In-flight

Assessments

Contributing Factors / Situations : Airport
Contributing Factors / Situations : Airspace Structure
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Human Factors

Narrative: 1

A helicopter was in the VFR traffic pattern. A [turboprop] was inbound on the GPS approach and was significantly faster than [the helicopter]. [A Cessna] was in the traffic pattern and taxiing back via on the tower frequency. [The helicopter] was sequenced ahead of a [turboprop] and [the Cessna] was told to hold short of Runway 31 for the arriving helicopter. While the helicopter was short final, the [turboprop] was overtaking the helicopter and it did not appear there would be sufficient runway separation. The local controller then asked [the helicopter] could make an approach to a taxiway, which the helicopter said they could. Local control then instructed [the helicopter] for the option on the taxiway midfield. [The helicopter] read back cleared for the option on the taxiway without saying anything about the midfield restriction. [The turboprop] was informed the helicopter would be for another intersection. [The helicopter] then overflew [the Cessna] who was on the taxiway holding short of the runway with no altitude restriction or other traffic issued.

I was in the process of relieving the Controller in Charge (CIC) position while fresh on the Ground Control position and did not hear much of the calls being made at the time the incident occurred. The local control did coordinate for the use of a Taxiway, but I did not realize where the location of [the Cessna] was until [the helicopter] was already over the top of the [Cessna]. [The helicopter] should have been sequenced to follow the [turboprop]. It was unrealistic to expect the slow helicopter to stay ahead of the much faster [turboprop]. Side stepping to the taxiway would have been ok except for an aircraft already on the taxiway and no restrictions were read back by the helicopter. I would think the restriction would have needed to be cross above 500 feet to avoid overflying the [Cessna] with no restrictions.

Synopsis

A Tower Controller in Charge reported a helicopter was instructed to land via a taxiway and did not comply with a restriction and overflew an aircraft awaiting takeoff.

Time / Day

Date : 201705

Local Time Of Day : 0001-0600

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.MSL.Single Value : 2800

Environment

Flight Conditions : IMC

Weather Elements / Visibility : Fog

Light : Night

Aircraft

Reference : X

ATC / Advisory.TRACON : ZZZ

Aircraft Operator : Air Taxi

Make Model Name : EC130

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 91

Flight Plan : VFR

Mission : Ferry

Nav In Use : GPS

Flight Phase : Cruise

Route In Use : Visual Approach

Airspace.Class E : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Taxi

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Commercial

ASRS Report Number.Accession Number : 1452132

Human Factors : Situational Awareness

Human Factors : Workload

Human Factors : Confusion

Human Factors : Distraction

Events

Anomaly.Inflight Event / Encounter : Weather / Turbulence

Anomaly.Inflight Event / Encounter : VFR In IMC

Detector.Person : Flight Crew

When Detected : In-flight

Result.Flight Crew : Took Evasive Action

Result.Flight Crew : Requested ATC Assistance / Clarification

Result.Flight Crew : Diverted
Result.Flight Crew : Became Reoriented
Result.Air Traffic Control : Issued New Clearance

Assessments

Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Contributing Factors / Situations : Weather
Primary Problem : Weather

Narrative: 1

The crew and I just completed a scene flight and were at the hospital. I refueled the aircraft and double checked weather prior to making our return leg to base. All weather reporting stations along our route were all reporting VFR. The closest weather reporting station to our base, was reporting winds 240 at 8 knots, 10 SM visibility, ceilings 9,000 feet scattered, temperature 75 degrees, dew point 64 degrees, humidity 84%, and about 16% illumination. Winds at 1,000 feet AGL was 250 26-28 knots. We departed to the northeast enroute back to base at 2,000 feet MSL, which is a 20 minute flight.

Approximately 15 minutes into the flight I noticed some small patches of fog below us at about 500 feet AGL. Our route takes us along the river, and we were approaching a power plant with several bright lights. Once we got to the power plant, the crew and I realized it was very hazy and I decided to deviate from our route and head northbound toward a local Airport. I could still see ground lights and cars driving on the roads. Weather wasn't looking much better to the north, so I made a slight left turn toward the northwest to attempt to get away from the river. I also elected to start a climb in the event we went in Inadvertent Instrument Meteorological Conditions (IIMC). I referenced the GPS and we were 11.3 NM south of the airport now at 2,500 feet. I already had the UNICOM frequency tuned in so I attempted to activate the airport lighting via radio clicks. I saw no signs of lights to the north, and ground lights were deteriorating directly below us. I told the crew we were IIMC and I was coming inside and committing to instruments.

I followed the IIMC procedure and got established on a northwest heading. I knew we were in the clouds at this point because the strobe light on the belly of the aircraft was reflecting into the cockpit, so I turned it off. Once I was at my MSA of 4,000 feet MSL, I made a small left turn to 270 and planned on recovering to a county airport as we had just been there previously and I knew it was VMC there when we left about an hour prior. I then switched up Approach control, which was in the standby frequency, and established communication and let them know I was [requesting priority handling] for IIMC. I elected to maintain our company discrete squawk code. I stated my altitude and heading and requested radar vectors to the County Airport. Once they had me on radar he had me turn left to 220 and that would put me on a track toward the airport, which was 14 miles away. After flying this track approximately 5 minutes we broke out of IMC conditions. I told ATC that I was now VMC and had the Airport in sight, but was going to stay committed onto the instruments until I got closer. I told ATC I requested to get set up for the ILS into the county airport for planning purposes. I then descend down to glide slope intercept altitude of 2,500 feet as I was still currently VMC and wanted to make sure I could stay that way at a lower altitude. Approach then advised me that they knew I said I had the airport in sight, but wanted to confirm and the Airport was 12 o'clock and 5 miles. I stated that indeed I had the airport in sight and could cancel the clearance and descend down to the airport VFR. We landed at the airport with no other issues.

Not much we can do to remedy this issue, except add more accurate weather reporting stations, especially in known troubled areas.

Synopsis

An EC130 helicopter pilot reported he unexpectedly entered IMC after doing a due diligence weather preflight which indicated VMC to his base airport. An IFR clearance was obtained enroute.

Time / Day

Date : 201705

Local Time Of Day : 1201-1800

Place

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : Marginal

Light : Daylight

Ceiling.Single Value : 1800

Aircraft

Reference : X

Aircraft Operator : Air Taxi

Make Model Name : SA 365 Dauphin 2

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 135

Flight Plan : None

Mission : Ambulance

Flight Phase : Landing

Airspace.Class G : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Taxi

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Commercial

ASRS Report Number.Accession Number : 1451748

Human Factors : Situational Awareness

Events

Anomaly.Ground Event / Encounter : Vehicle

Detector.Person : Other Person

When Detected.Other

Assessments

Contributing Factors / Situations : Human Factors

Primary Problem : Human Factors

Narrative: 1

We arrived prior to the required show time and set up for our high recon, and during that high recon I noted a white van blocking the drive to the helipad on the north end, and a white pickup truck blocking drive to helipad on the south end, additionally there is the standard large emergency generator located NW of helipad. Wind was predominantly out

of the SE, but shifting with the counter clockwise motion of the weather pattern. I continued around to set up for a steep approach from the NW to the SE to take advantage of the wind. Rate of closure was slow, and descent rate was our 200 ft FPM. From my perspective, approach was normal. At the bottom, with shifting winds and ingestion of aircraft's own rotor wash, there was the standard yaw back and forth. I finished DFL (Daily Flight Log) and started new line on DFL with all the items I could pre-fill out (weight and balance, start, pilot, and number on board as well as departure point) in case we were called out for a medical flight. I then put log book up. Meantime crew had gotten out, put wheel chocks down, and were trying to figure out what we were supposed to do. If memory serves me, we had some staff come up to ask questions about the aircraft, and I was talking to one staff member when a security guard came up, so I walked over to him and he told me something to the effect "You know you hit the van" to which I was taken aback and said something like no, I felt nothing - did I damage the van? He replied, something to the effect of we don't care about the van. This all occurred approximately 10 or 15 minutes after we had been on the ground. I told him I would look at the aircraft. I failed to mention had already done my post flight walk around and had not noted anything out of the ordinary after I finally got out of the aircraft. I immediately went back to the back of the aircraft and re looked at the tail section and the tail stinger. I noted no indication of a strike. The van was all white and, since we are predominately black, I looked at it to see if I could see any indication that I had hit it and could not note any marks that would have given me that indication. So here was my quandary, what to do next. I could see no physical evidence of a having hit the van on either the aircraft or the van. Do I call a mechanic? I kept going back to look at tail, tail stinger, wheels of aircraft, etc. I could not see anything. My thought process turned to treating like a bird strike for non-moving portions of aircraft and clearing it for RTS (Return to Service). My rationale was I felt this individual who approached may have thought it appeared that I hit the vehicle from his angle or perspective, and I did not feel during the approach, nor see any indication that there was in fact, contact. The following day, I accepted an IFR Flight. Once back, Mechanic noted lens cover for aft tail light broken on A Check. He showed me. When replacing with new cover, he noted small chip in lower right underneath portion of tail cone along with a rub mark above that. Repairs were made.

Synopsis

AS-365 Captain reported contact with a van on landing at a hospital helipad.

Time / Day

Date : 201705
Local Time Of Day : 1201-1800

Place

Locale Reference.ATC Facility : DEN.Tower
State Reference : CO

Environment

Flight Conditions : VMC
Light : Daylight

Aircraft : 1

Reference : X
ATC / Advisory.Tower : DEN
Aircraft Operator : FBO
Make Model Name : Helicopter
Crew Size.Number Of Crew : 1
Flight Phase : Cruise
Airspace.Class B : DEN

Aircraft : 2

Reference : Y
ATC / Advisory.Tower : DEN
Aircraft Operator : Air Carrier
Make Model Name : Regional Jet CL65, Undifferentiated or Other Model
Crew Size.Number Of Crew : 2
Operating Under FAR Part : Part 121
Flight Plan : IFR
Mission : Passenger
Flight Phase : Final Approach
Route In Use : Visual Approach
Airspace.Class B : DEN

Person

Reference : 1
Location Of Person.Facility : DEN.TWR
Reporter Organization : Government
Function.Air Traffic Control : Local
Qualification.Air Traffic Control : Fully Certified
Experience.Air Traffic Control.Time Certified In Pos 1 (yrs) : 7.75
ASRS Report Number.Accession Number : 1451607
Human Factors : Training / Qualification
Human Factors : Situational Awareness

Events

Anomaly.ATC Issue : All Types
Anomaly.Deviation - Procedural : Published Material / Policy

Detector.Person : Observer
When Detected : In-flight
Result.Flight Crew : Requested ATC Assistance / Clarification
Result.Flight Crew : Took Evasive Action
Result.Air Traffic Control : Issued New Clearance
Result.Air Traffic Control : Separated Traffic

Assessments

Contributing Factors / Situations : Airport
Contributing Factors / Situations : Company Policy
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Company Policy

Narrative: 1

I was working Local Control. Aircraft X departed FTG needed to head west (275 on course heading) to destination. Recently our supervisor had encouraged us to keep (as much as possible) all [helicopters] on course and encouraged our crew to cross landing runways and over the approach ends of arrival runways when appropriate. I attempted to comply with this request (though he was not working that day) however I was trained differently. Trained NOT to delay a [helicopter] but to keep as much traffic moving as possible (all traffic). I had been given performance counseling for having a [helicopter] proceed direct the tower, depart tower southbound, proceed on course and was accused or told that I was delaying [the helicopter], so I wanted to with comply with our new directions and am on board to provide the best service we can.

I called traffic to landing traffic to the left runway as well as to Aircraft X with the intention to cross the approach end no less than 500 feet over landing traffic. That didn't work, I had to apply visual separation and have the Aircraft X pass behind the CRJ on final to the left runway and he was now not aligned/set-up for an approach end crossing. I decided to keep him headed west to go through the other final and I attempted a point out with the other Local Controller AFTER calling traffic to Aircraft X for the CRJ on final to RWY 34R.

The button/touch-screen on the RDVS (Rapid Deployment Voice Switch) didn't work (it rarely does and when it does it goes in and out and in and out of connection). Instead I had to shout across the tower and coordinate his heading, that he would pass behind [the CRJ] and then proceed on course westbound on a 275 heading. Meanwhile Aircraft X is getting closer to [the CRJ] who is on final for the right runway. As I was about to tell Aircraft X to hold his position, he announced a southbound 360 turn (he had done this prior with the first CRJ on 35L when I told him to "hold his position" and executed a southbound 360 which threw me.) I had never seen that before, was not trained that I can remember that Helicopters needed/or may do that when told to hold. I allowed him to do execute/begin his south 360, had him pass behind the CRJ and proceed on course. I was told that because I didn't tell Aircraft X a control instruction FIRST, prior to him telling me his turn, that I had a loss of separation despite using tower applied visual separation. I didn't feel the need to reiterate what he was doing, as that's what I wanted and anticipated him to do in the first place. I suppose I should have just told him to hold his position prior to attempting coordination with the other Local Controller. I had visual on Aircraft X and all landing traffic the entire time.

Apparently, [the CRJ] reported after landing that "it was a close one," with the helicopter on final. I have no idea if they called traffic to their [aircraft]. Training was in progress at

the other Local Control. This is my first issue with VFR to IFR traffic.

Personally, I would have gone with my gut instinct and previous training and departed the Aircraft X southbound for 1-2 miles then had him proceed on course. Altitude separation would have been maintained without effort, there would have been no disruption to aircraft landing on final and Aircraft X would have been able to proceed without delay. I could have also gone northbound and crossed over the arrival runways midfield, or direct the tower. I go so focused on the newer "directive" that common sense and previous methodology seemed to go out the door. I felt I had to stick with the original plan and I suppose felt stuck.

This concept of stopping all applicable traffic is newer here. It may sound odd but in training and up until semi-recently the environment has changed regarding priority handling and working traffic in general. It seems that it's hard to put into practice after having the other side of the coin pounded into your mind. No one has a major problem with this change, but making the change or executing the change is challenging for some. Some practice in our refresher training would be good (especially with helicopter's not getting traffic in sight). Prior we had a certain way of running helicopters that made it easy for all traffic to continue and required little in the way of vectors, traffic calls etc. Some are struggling with it. I'm not the only one.

Fix the dang RDVS at the position. I have been here almost 8 years and it's been a problem for that long. The excuse/reason it doesn't get fixed doesn't grant eight years of not getting it fixed. It's a problem no matter who you are trying to call from that position. It's terrible.

Synopsis

DEN Tower Controller attempted to use a new procedure that allowed a helicopter and arriving aircraft to get too close causing the helicopter to take evasive action.

Time / Day

Date : 201705

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : DCA.Airport

State Reference : DC

Altitude.MSL.Single Value : 900

Aircraft

Reference : X

ATC / Advisory.Tower : DCA

Aircraft Operator : Military

Make Model Name : Helicopter

Flight Plan : VFR

Flight Phase : Cruise

Airspace.Class B : DCA

Person : 1

Reference : 1

Location Of Person.Facility : PCT.TRACON

Reporter Organization : Government

Function.Air Traffic Control : Approach

Function.Air Traffic Control : Departure

Qualification.Air Traffic Control : Fully Certified

Experience.Air Traffic Control.Time Certified In Pos 1 (yrs) : 9

ASRS Report Number.Accession Number : 1449645

Human Factors : Communication Breakdown

Human Factors : Human-Machine Interface

Human Factors : Situational Awareness

Human Factors : Workload

Human Factors : Distraction

Communication Breakdown.Party1 : ATC

Analyst Callback : Attempted

Person : 2

Reference : 2

Location Of Person.Facility : DCA.TOWER

Reporter Organization : Government

Function.Air Traffic Control : Other / Unknown

Qualification.Air Traffic Control : Fully Certified

Experience.Air Traffic Control.Time Certified In Pos 1 (yrs) : 10

ASRS Report Number.Accession Number : 1449655

Human Factors : Distraction

Human Factors : Human-Machine Interface

Human Factors : Situational Awareness

Human Factors : Confusion

Events

Anomaly.ATC Issue : All Types
Anomaly.Conflict : Airborne Conflict
Anomaly.Deviation - Track / Heading : All Types
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : Clearance
Anomaly.Inflight Event / Encounter : Weather / Turbulence
Detector.Person : Air Traffic Control
When Detected : In-flight
Result.Air Traffic Control : Separated Traffic

Assessments

Contributing Factors / Situations : Airspace Structure
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

Presidential movements continue to be an issue between DCA and PCT. Aircraft X was ADW inbound to P-56B. DCA tower called with a 3 minute to lift call off ADW which is 7 miles SE of DCA. We begin holding arrivals at that point. We were just beginning an arrival push and approach/final had 15 planes or more.

While we were holding airplanes in the sky and backing up ZDC, DCA tower continued to release airplanes compounding the issue. A lot of arrivals spinning and more departures entering the NAS is a dangerous game for DCA tower to play. DCA tower took it two steps further this movement by launching two departures with Aircraft X with less than a mile a no altitude, converging.

How is it we on approach are not allowed to run arrivals yet they have the authority to release airplanes right at presidential aircraft?

Advise DCA tower the needs of the TRACON during these movements and educate them on proper coordination. Develop a Work group between DCA/PCT/ADW on VIP movements.

Narrative: 2

I was working Aircraft X from ADW to the National Observatory (NOB). On initial contact, Aircraft X advised that they would be using alternate routing. I acknowledged their transmission and advised the tower supervisor and local controller. Aircraft X proceeded via Woods Corner - to the river - route 4 - route 1 - to the NOB [National Observatory]. I was advised later on that PCT MTV [Mount Vernon Area] had concerns about the amount of time that arrivals were stopped and about departures off of DCA. Basic separation was maintained and I had Aircraft X in sight from WC all the way to their destination.

We do not question when a Presidential or Vice Presidential aircraft changes its route. If they could provide earlier notification then initial call on frequency it would be optimal. We understand when bad weather forces a change.

Synopsis

PCT TRACON and DCA Tower Controllers reported an unsafe situation involving VIP movements.

Time / Day

Date : 201705
Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport
State Reference : US
Relative Position.Distance.Nautical Miles : 7
Altitude.MSL.Single Value : 3000

Environment

Flight Conditions : VMC
Weather Elements / Visibility.Visibility : 10
Light : Daylight
Ceiling.Single Value : 7000

Aircraft

Reference : X
Make Model Name : Eurocopter AS 350/355/EC130 - Astar/Twinstar/Ecureuil
Crew Size.Number Of Crew : 1
Operating Under FAR Part : Part 91
Flight Plan : VFR
Mission : Photo Shoot
Flight Phase : Climb
Route In Use : Direct
Airspace.Class E : ZZZ

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Function.Flight Crew : Pilot Flying
Function.Flight Crew : Single Pilot
Qualification.Flight Crew : Flight Instructor
Qualification.Flight Crew : Commercial
Experience.Flight Crew.Total : 6000
Experience.Flight Crew.Last 90 Days : 100
Experience.Flight Crew.Type : 4000
ASRS Report Number.Accession Number : 1449330
Human Factors : Confusion

Events

Anomaly.No Specific Anomaly Occurred : All Types
Detector.Person : Flight Crew
Were Passengers Involved In Event : N
When Detected : In-flight
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

While on a routine Photography Mission, repositioning to another location, we became concerned [City] Power Plant would misinterpret our aircraft as a security issue. Upon landing we contacted [local] 911. They had no report of complaints or concerns. We asked the 911 Dispatcher Officer to forward our contact information to [City] Power Plant Security; if they had any questions or concerns to contact us.

Synopsis

AS350 helicopter pilot reported concerns that a photo mission in the vicinity of a power plant might be misinterpreted as a security issue.

Time / Day

Date : 201705

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : FTG.Airport

State Reference : CO

Environment

Flight Conditions : VMC

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.Tower : FTG

Aircraft Operator : Air Taxi

Make Model Name : Helicopter

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Flight Plan : IFR

Mission : Training

Flight Phase : Takeoff

Airspace.Class D : FTG

Person : 1

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Taxi

Function.Flight Crew : Captain

Function.Flight Crew : Check Pilot

Function.Flight Crew : Pilot Not Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1448941

Human Factors : Situational Awareness

Person : 2

Reference : 2

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Taxi

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1448943

Events

Anomaly.Conflict : Airborne Conflict
Anomaly.Deviation - Procedural : Clearance
Anomaly.Ground Incursion : Runway
Detector.Person : Flight Crew
When Detected : In-flight

Assessments

Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

My first IFR departure from the Front Range airport. FTG was doing IFR departures from Runway 8. As noted in the ATIS Tango. I called tower and requested air taxi to the A6 taxiway for a mid-field departure. I directed [the Pilot Flying (PF)] to land the aircraft on the A6 taxiway into the wind which was strong out of the East. Which is why I wanted the midfield departure as I wanted to avoid a downwind air taxi to the approach end of Runway 8. My mind set was a runway departure. But the tower was expecting a departure from the taxiway as most all of our aircraft depart in that manner. When we were cleared for takeoff I directed PF to turn towards the runway as he was beginning a departure from over the grass between the runway and the taxiway. He did a clearing pedal turn (good for him) towards the runway and I looked over my left shoulder to see a Cessna directly overhead on a departure from the runway. I announced stop over the intercom and we did. We then heard the tower calling traffic to the departing Cessna that a helicopter was departing the Alpha taxiway. Then we both realized that our take off clearance was from the taxiway not the runway. We are not sure if we crossed the hold line but that is a possibility. The rest of the flight was uneventful.

We both should have listened more intently to the tower communications and not assume the clearance was for the runway. Also during our briefing we discussed that if ever one of us is confused about anything that pilot should let the other pilot know about it. We were both confused. Had we admitted that earlier the potential runway incursion might not have happened.

One last thing. We both were very intent on clearing before entering the runway. PF did the clearing turn and I looked. There for we shall continue to do those things we learned in flight school.

Narrative: 2

[Report narrative contained no additional information.]

Synopsis

Helicopter flight crew reported a takeoff from a taxiway that may have drifted towards the runway being used by a fixed wing aircraft.

Time / Day

Date : 201705

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : MLI.Airport

State Reference : IL

Altitude.AGL.Single Value : 500

Environment

Flight Conditions : VMC

Weather Elements / Visibility.Visibility : 10

Light : Daylight

Ceiling.Single Value : 10000

Aircraft : 1

Reference : X

ATC / Advisory.TRACON : MLI

Aircraft Operator : Air Taxi

Make Model Name : Helicopter

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 135

Flight Plan : VFR

Mission : Ambulance

Flight Phase : Initial Climb

Route In Use : Direct

Airspace.Class C : MLI

Aircraft : 2

Reference : Y

ATC / Advisory.Tower : MLI

Aircraft Operator : Air Carrier

Make Model Name : Commercial Fixed Wing

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Mission : Passenger

Flight Phase : Final Approach

Airspace.Class C : MLI

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Carrier

Function.Flight Crew : Single Pilot

Qualification.Flight Crew : Rotorcraft

Qualification.Flight Crew : Commercial

Qualification.Flight Crew : Multiengine

Qualification.Flight Crew : Instrument
Experience.Flight Crew.Total : 6200
Experience.Flight Crew.Last 90 Days : 45
Experience.Flight Crew.Type : 850
ASRS Report Number.Accession Number : 1448460
Human Factors : Communication Breakdown
Human Factors : Situational Awareness
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : ATC

Events

Anomaly.Conflict : NMAC
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Automation : Aircraft RA
Detector.Person : Flight Crew
Detector.Person : Air Traffic Control
Miss Distance.Vertical : 300
When Detected : In-flight
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

While taking off from a helipad and climbing to 400 to 500 feet AGL, I contacted Quad City Approach and received a new squawk code when the aircraft TCAS alert went off. As I was responding to Quad City Approach I saw an airliner fly above us. I was advised by Quad City the airliner passed over us by 300 feet. I estimate we were approximately 1100 to 1200 feet MSL when we had the airliner fly 300 feet above our helicopter.

Radio contact with Quad City approach when taking off from the helipad is best if we can get a little altitude. It is not normally in the approach path of aircraft coming into MLI so it has never been a safety issue to contact ATC shortly after liftoff. The airliner must have been on Quad City tower frequency and I was on Quad City Approach frequency.

Synopsis

Helicopter pilot reported a NMAC with an airliner in the vicinity of MLI airport.

Time / Day

Date : 201705

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 700

Environment

Flight Conditions : VMC

Light : Night

Aircraft : 1

Reference : X

ATC / Advisory.Tower : ZZZ

ATC / Advisory.UNICOM : ZZZ

Aircraft Operator : Government

Make Model Name : Helicopter

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Flight Plan : None

Flight Phase : Cruise

Airspace.Class C : ZZZ

Airspace.Class E : ZZZ

Aircraft : 2

Reference : Y

ATC / Advisory.Tower : ZZZ

ATC / Advisory.UNICOM : ZZZ

Aircraft Operator : Government

Make Model Name : Helicopter

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Flight Plan : None

Mission.Other

Flight Phase : Cruise

Route In Use : None

Airspace.Class C : ZZZ

Airspace.Class E : ZZZ

Aircraft : 3

Reference : Z

ATC / Advisory.CTAF : ZZZ

Make Model Name : Helicopter

Crew Size.Number Of Crew : 2

Flight Phase : Cruise

Airspace.Class C : ZZZ

Airspace.Class E : ZZZ

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Government
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Flight Instructor
Qualification.Flight Crew : Air Transport Pilot (ATP)
Qualification.Flight Crew : Instrument
Experience.Flight Crew.Total : 5000
Experience.Flight Crew.Last 90 Days : 45
Experience.Flight Crew.Type : 500
ASRS Report Number.Accession Number : 1447789
Human Factors : Communication Breakdown
Human Factors : Confusion
Human Factors : Situational Awareness
Human Factors : Time Pressure
Human Factors : Workload
Human Factors : Distraction
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Conflict : NMAC
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Person : Observer
Detector.Person : Flight Crew
Miss Distance.Horizontal : 100
Miss Distance.Vertical : 300
When Detected : In-flight
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Airspace Structure
Contributing Factors / Situations : Environment - Non Weather Related
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

At approximately XA46, Aircraft X and Aircraft Y responded to a stranded hiker. After approximately 20 minutes of searching low level in the canyon, we located the stranded hiker and hoisted our rescuer down for patient care. After hoisting the rescuer down, we repositioned into a 60-knot right orbit between the rescue site and the Freeway awaiting Aircraft Y's command to come back in for the rescue.

After about 5 minutes, Aircraft Y called us back in to the rescue site to retrieve our rescuer, so we rolled into a north bound turn from our holding orbit. As I rolled out, I looked up and to the right and saw a night sun equipped aircraft converging above and to the right which I believed to be Aircraft Y in a right-hand orbit.

During the next couple seconds, I began a descent with what I believed was Aircraft Y "in-

sight" and noticed the night sun beam rapidly sweeping towards us. I continued our north bound descent as the night sun beam hit our aircraft and swept through the cockpit from what I believed was Aircraft Y passing overhead.

At this point, the co-pilot and safety member in the right rear cabin area also had eyes on the converging aircraft. We all estimated our altitude separation to be approximately 300' as the converging aircraft passed overhead.

While a 300-foot altitude separation is not uncommon between hoist and firefighting aircraft that are in communication with each other, this incident should be considered a near miss as the aircraft involved were in close proximity but not in communication. Because of the initial rescue site being in [a] tower controlled airspace, we were not monitoring adequately for any traffic advisories in the area. Both rescue aircraft were monitoring the tower frequency intermittently, air-to-air, and the rescue tactical.

As always, there was task saturation with the combination of rescue briefings in the aircraft, radio traffic with the ground companies and air traffic control during the rescue. Aircraft typically monitors [traffic advisories] but also became task saturated while developing a rescue plan with the incident commander on the ground. It's also likely that while we were in [the Class C] airspace at the rescue site and monitoring their frequency, we were out of radar contact due to the obstruction of [the mountain].

Immediately after the near miss, the co-pilot of the rescue broadcast on [traffic advisory frequency] that Aircraft Y and Aircraft X were working in the [mountain] area below 1700 feet for any media ships that might be in the area. What we think was Aircraft Z responded that they were near the Freeway.

Contributing factors to the near miss event:

- * We did not have TCAS displayed on the co-pilots MFD of the rescue aircraft which would have alerted us to the converging aircraft.
- * My misidentification of the rescue aircraft as "Aircraft Y" with a night sun, resulted in my comfort in passing below, what I thought was Aircraft Y, rather than executing evasive maneuvers.
- * Once we moved south from the rescue site, we were out of class C airspace and should have monitored/ self-announced [our position].
- * Because the rescue site was on the boundary of the southern edge of [the Class C] airspace, both rescue aircraft were monitoring [tower] but not [common traffic frequency].

Even though we are engaged in high risk hoist rescue operations in the mountains and foothills at night, we need to continue to be vigilant in assigning one of the pilots in either the rescue aircraft or the rescue aircraft the task of monitoring [common traffic frequency]. Any aircraft on scene should also have the TCAS selected to the co-pilots MFD to help with early identification of traffic conflicts.

Synopsis

Rescue Helicopter pilot reported a near miss at night with what the crew thought was an accompanying aircraft. In reality was an unidentified aircraft.

Time / Day

Date : 201705
Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : LGA.Airport
State Reference : NY
Altitude.MSL.Single Value : 1500

Environment

Flight Conditions : VMC
Weather Elements / Visibility.Visibility : 10
Light : Daylight
Ceiling.Single Value : 25000

Aircraft : 1

Reference : X
ATC / Advisory.Tower : LGA
Make Model Name : Helicopter
Crew Size.Number Of Crew : 1
Operating Under FAR Part : Part 91
Flight Plan : None
Mission : Passenger
Flight Phase : Cruise
Airspace.Class B : LGA

Aircraft : 2

Reference : Y
ATC / Advisory.Tower : LGA
Aircraft Operator : Personal
Make Model Name : Small Aircraft
Crew Size.Number Of Crew : 1
Operating Under FAR Part : Part 91
Flight Plan : VFR
Flight Phase : Cruise
Airspace.Class B : LGA

Person : 1

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Function.Flight Crew : Pilot Flying
Function.Flight Crew : Single Pilot
Qualification.Flight Crew : Commercial
Qualification.Flight Crew : Flight Instructor
Qualification.Flight Crew : Instrument
Experience.Flight Crew.Total : 2605
Experience.Flight Crew.Last 90 Days : 74
Experience.Flight Crew.Type : 1200

ASRS Report Number.Accession Number : 1447142
Human Factors : Situational Awareness
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Person : 2

Reference : 2
Location Of Person.Aircraft : Y
Location In Aircraft : Flight Deck
Reporter Organization : Personal
Function.Flight Crew : Pilot Flying
Function.Flight Crew : Single Pilot
Qualification.Flight Crew : Instrument
Qualification.Flight Crew : Private
Experience.Flight Crew.Total : 409
Experience.Flight Crew.Last 90 Days : 2
Experience.Flight Crew.Type : 228
ASRS Report Number.Accession Number : 1447171
Human Factors : Situational Awareness
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Conflict : NMAC
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Person : Flight Crew
Miss Distance.Horizontal : 20
Miss Distance.Vertical : 10
When Detected : In-flight
Result.Flight Crew : Took Evasive Action

Assessments

Contributing Factors / Situations : Airspace Structure
Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

Checked in with LGA at 1.5 north on Hudson for a tour, LGA informed pilot of traffic ahead helicopter 1.5 northbound and traffic behind 1 mile 1.5 northbound. Pilot informed LGA that he has traffic ahead insight and would maintain visual, also informed LGA that he would look for traffic behind in the upcoming turn. Shortly later pilot checked out from LGA. Immediately after checking out pilot looks left just before initiating turn and sees fixed wing fly by... same alt 20 feet off left hand side.

Narrative: 2

I was flying the NYC Skyline Route northbound at an ATC-assigned altitude of 1500 MSL. At approximately the Intrepid reporting point, ATC advised helicopter traffic at 11 o'clock & 2 miles and additional traffic 2 o'clock & 1 mile. I responded that I had the 11 o'clock in sight but not the 2 o'clock. I observed the 11 o'clock helicopter approximately 50 feet above and above the western shore of the Hudson at approximately 1 mile. As I proceeded

northbound, the 11 o'clock helicopter crossed the Hudson from west to east and began hovering slightly above my flight path. Thinking that the helicopter intended to maintain its position or continue eastbound, I adjusted my course to maintain visual separation from the helicopter by passing below and to the left of the helicopter, but still roughly along the east bank of the Hudson. At no time did I lose visual contact with the helicopter. After my passage, the helicopter radioed his displeasure to ATC for what he considered "closer than a close call."

While I believe I maintained a safe degree of separation from the helicopter throughout, I concede that it would have been safer if I had moved further towards the west bank of the Hudson to pass the helicopter. However, I was concerned that this would be considered a deviation as the Skyline Route instructions are to follow the east bank of the Hudson northbound. Certainly an altitude change would not have been possible given the operation within Class B airspace. I believe there is confusion over how tightly pilots are expected to follow the banks of the river. Additionally, in the past when flying this route I have received additional vertical separation from other traffic, especially helicopter traffic, by being assigned 2000 MSL. Finally, it would be helpful if traffic in the Class B flying north/south along the Hudson were separated vertically from traffic crossing the Hudson as the possibility of conflicts are greater in these cases. There is precedent for this vertical separation as the Hudson SFRA mandates transient operation between 1000-1299 MSL and local operation between SFC-999 MSL.

Synopsis

A helicopter pilot and a small aircraft pilot reported a NMAC over the Hudson River.

Time / Day

Date : 201704

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.MSL.Single Value : 500

Environment

Flight Conditions : VMC

Weather Elements / Visibility.Visibility : 10

Light : Daylight

Ceiling.Single Value : 20000

Aircraft : 1

Reference : X

ATC / Advisory.CTAF : ZZZ

Aircraft Operator : FBO

Make Model Name : Helicopter

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Mission : Passenger

Flight Phase : Cruise

Airspace.Class G : ZZZ

Aircraft : 2

Reference : Y

Aircraft Operator : Corporate

Make Model Name : UAV - Unpiloted Aerial Vehicle

Operating Under FAR Part.Other

Mission : Photo Shoot

Flight Phase : Cruise

Airspace.Class G : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : FBO

Function.Flight Crew : Single Pilot

Qualification.Flight Crew : Commercial

Qualification.Flight Crew : Rotorcraft

Experience.Flight Crew.Total : 7970

Experience.Flight Crew.Last 90 Days : 25

Experience.Flight Crew.Type : 1650

ASRS Report Number.Accession Number : 1445520

Human Factors : Communication Breakdown

Human Factors : Training / Qualification

Human Factors : Situational Awareness
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Ground Personnel

Events

Anomaly.Conflict : Airborne Conflict
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : FAR
Detector.Person : Ground Personnel
When Detected : In-flight
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

Individual claiming to be a commercial drone operator photographing a kite festival along the beach called the airport stating that I was violating his allowed 400 ft altitude while I was conducting a helicopter tour. I am well aware of the kite business on the boardwalk and always fly that location at 500 ft or above to avoid any kites. I did not see the drone that was apparently close to me and the individual would not give his name or any information to either the airport or to my employer. If the person was indeed an approved Part 107 operator I don't feel he is willing to work with aviation businesses in the area by refusing to identify himself and threatening established aviation business in the area. I don't really know what can be done with an individual like this that doesn't want to communicate or how to correct the situation. Seems to be more of a problem everywhere other than just here locally.

Synopsis

Helicopter pilot reported a UAV operator stated he was interfering with his commercial business along a boardwalk.

Time / Day

Date : 201705

Local Time Of Day : 1801-2400

Place

Locale Reference.ATC Facility : SMO.Tower

State Reference : CA

Altitude.MSL.Single Value : 1900

Environment

Flight Conditions : Marginal

Light : Daylight

Aircraft : 1

Reference : X

ATC / Advisory.Tower : SMO

Aircraft Operator : Fractional

Make Model Name : Light Transport, Low Wing, 2 Turboprop Eng

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 135

Flight Plan : IFR

Mission : Passenger

Flight Phase : Final Approach

Airspace.Class D : SMO

Aircraft : 2

Reference : Y

ATC / Advisory.Tower : SMO

Aircraft Operator : Corporate

Make Model Name : Helicopter

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 91

Flight Plan : VFR

Mission : Passenger

Flight Phase : Cruise

Airspace.Class D : SMO

Person : 1

Reference : 1

Location Of Person.Facility : SMO.TOWER

Reporter Organization : Government

Function.Air Traffic Control : Local

Qualification.Air Traffic Control : Fully Certified

Experience.Air Traffic Control.Time Certified In Pos 1 (mon) : 7

ASRS Report Number.Accession Number : 1444875

Person : 2

Reference : 2
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Fractional
Function.Flight Crew : Captain
Function.Flight Crew : Pilot Flying
Qualification.Flight Crew : Air Transport Pilot (ATP)
ASRS Report Number.Accession Number : 1445341
Human Factors : Communication Breakdown
Human Factors : Distraction
Human Factors : Situational Awareness
Human Factors : Time Pressure
Human Factors : Workload
Human Factors : Confusion
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : ATC

Events

Anomaly.ATC Issue : All Types
Anomaly.Conflict : Airborne Conflict
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Deviation - Procedural : Clearance
Anomaly.Inflight Event / Encounter : Weather / Turbulence
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Took Evasive Action
Result.Flight Crew : Executed Go Around / Missed Approach
Result.Air Traffic Control : Provided Assistance

Assessments

Contributing Factors / Situations : Procedure
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Weather
Primary Problem : Weather

Narrative: 1

I had been on Local for about an hour. During that time, weather had changed rapidly from good VFR to low IFR as a low overcast marine layer moved in quickly. It was still reported clear to the east of the field, and I could still see the RWY 21 final from the tower. Within the few minutes leading up to this event, GC/FD and the CIC had generated a special observation that showed the airport IFR and passed it to concerned parties.

Aircraft Y exited LAX airspace and requested a transition northbound, in VFR conditions, via the I-405 freeway, which intersects the RWY 21 centerline at about a 3/4 mi final. That aircraft was at 1300 ft. Around the same time, I received the hand off on an arrival, Aircraft X. Scratch pad coordination at the time of the hand off showed this aircraft assigned "V21" (visual approach), but that would not have been appropriate with the newest weather observation. This coordination notation was later removed, indicating that the aircraft would arrive on the VOR-A approach. I used the STARS PTL (Predicted Track Line) feature (vector lines) to determine that Aircraft Y would get across the RWY 21 centerline in time, and I advised Aircraft Y that they would be crossing my final in advance of an arriving jet.

Aircraft X subsequently checked on late, high, and with faster ground speed than I would normally anticipate at that stage. Step down altitude at WURUD is 1540 ft (a 3 mi final), but I recall Aircraft X crossed that point above 3000. I advised Aircraft X of the traffic (now 1/2 mi south of the centerline at 1300 and heading northbound) and issued landing clearance. Just afterward, I observed Aircraft Y passing the extended centerline, as Aircraft X was on a 2 mi final, also noting that they had arrested their descent at 1900 ft. I advised Aircraft X that their traffic was clear of final. On a 1 mile final, Aircraft X reported missed approach, still at 1900 ft and passing 1 mile south of the diverging traffic at 1300 ft. I issued missed approach instructions in accordance with the SCT LOA and performed required coordination. I switched Aircraft X to SCT Malibu sector. Before going over, the pilot informed me he had received an RA with the traffic.

Aircraft X returned later and landed via the RNAV GPS 21 approach. I asked the pilot for some more information about the RA situation. I had guessed, and the pilot confirmed, that they were unexpectedly "dumped" on the VOR-A approach. The pilots had briefed and were expecting the RNAV GPS 21 approach. Per local procedures, SMO ATIS should advertise both the VOR-A and RNAV GPS 21 approaches under these conditions. SCT Burbank area may issue either approach. I did not record or listen to the ATIS at the time because that is not a LC responsibility.

I would not have approved Aircraft Y's I-405 transition with an aircraft arriving RWY 21 on [a] day where weather was not a consideration. However, this was a complex decision in that Aircraft Y had a need to maintain VFR east of the cloud layer. My judgment was correct that this aircraft would pass the centerline in advance of the arriving jet. Plus, I realized that Aircraft X would be out of position somehow, but I admit I did not know what the pilot's actions would be. Aircraft X's higher-than-anticipated ground speed and trajectory ended up reducing the separation. Ideally, Aircraft X would have been permitted to fly a stable approach and would have passed well beneath and behind the traffic, but the actual situation generated a TCAS RA because the device projected the aircraft descending on top of the traffic.

I think the important lessons here are:

1. Knowingly anticipating that an aircraft will have an unpredictable/unusual flight path should be a case for more positive separation. I could have asked Aircraft Y to fly eastbound until Aircraft X was in sight as weather would not have been a factor to the east. My Plan A (with Aircraft Y expeditiously crossing final) was very conditional, I realize.

2. SCT's handling of the flight, Aircraft X was never in a position to land and a missed approach/go-around was likely regardless of the crossing traffic. This underscores the importance of adequate vectoring to allow an aircraft to fly a stable approach. Also at issue was possible mis-coordination or miscommunication regarding the approach to be flown by the Aircraft X crew. The weather changed very rapidly, but I believe our tower team made every attempt to provide the latest information to the arrival controller.

The RNAV GPS 21 approach has been commissioned for [a short period] at the time of writing. It's hard for me to say what happened on that end, but I suppose the pilots may have briefed the RNAV approach as it would be preferred in general (LPV minimums), but the arrival controller may not have had the comfort and familiarity with that approach to issue it on very short notice.

Narrative: 2

On arrival into SMO, ATIS reported Marginal VFR and all approaches were available. We briefed the RNAV GPS RW 21 approach. ATC gave us direct DARTS, descend and maintain 4000. Outside of MIPTTE, ATC said "Cleared for the VOR A Approach", we were shocked and wondered why we were assigned this approach. Altitude was approximately 1800 feet. I looked outside and noticed crossing traffic, we then executed a missed approach.

There was heavy saturation regarding communication. With different approaches and traffic, we executed a No-Fault Missed Approach. During the Missed, I then requested for the RNAV GPS RWY 21 approach and landed.

Synopsis

SMO Tower Controller and inbound jet pilot reported an airborne conflict between a jet arrival and a helicopter transitioning the area when weather deteriorated.

Time / Day

Date : 201704

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : EHR.Airport

State Reference : KY

Altitude.AGL.Single Value : 300

Environment

Flight Conditions : VMC

Weather Elements / Visibility.Visibility : 10

Light : Daylight

Ceiling.Single Value : 12000

Aircraft : 1

Reference : X

ATC / Advisory.CTAF : EHR

Aircraft Operator : Personal

Make Model Name : Small Aircraft, Low Wing, 1 Eng, Fixed Gear

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 91

Flight Plan : IFR

Mission : Personal

Flight Phase : Initial Climb

Airspace.Class G : EHR

Aircraft : 2

Reference : Y

ATC / Advisory.CTAF : EHR

Make Model Name : Helicopter

Flight Phase : Initial Climb

Airspace.Class G : EHR

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Personal

Function.Flight Crew : Pilot Flying

Function.Flight Crew : Single Pilot

Qualification.Flight Crew : Private

Qualification.Flight Crew : Instrument

Experience.Flight Crew.Total : 2023

Experience.Flight Crew.Last 90 Days : 8

Experience.Flight Crew.Type : 985

ASRS Report Number.Accession Number : 1443795

Human Factors : Situational Awareness

Human Factors : Communication Breakdown

Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Conflict : NMAC
Detector.Person : Flight Crew
Miss Distance.Horizontal : 200
Miss Distance.Vertical : 0
When Detected : In-flight
Result.Flight Crew : Took Evasive Action

Assessments

Contributing Factors / Situations : Procedure
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Airport
Primary Problem : Human Factors

Narrative: 1

As I was preparing to land, a target was showing up on the TCAS on descent into EHR, I thought it was another plane, but it was not broadcasting. I tried to contact it with no response. I was able to activate the pilot controlled lighting on the CTAF, so I know [1] was tuned in to the right frequency. There was a helicopter on the ground when we landed.

We unloaded some things. I announced my intentions to takeoff on the CTAF. There was no response. Shortly after I departed, a helicopter suddenly popped up within 200 feet of my plane. The helicopter was flying in the same direction as me parallel to my aircraft. I turned quickly to the right and continued climbing to create more distance between me and the helicopter. I tried contacting it on CTAF, but there was no answer. I never got a response from it. It did not register on my TCAS.

Synopsis

Pilot of a small aircraft departing an uncontrolled airport reported a near miss with a helicopter departing at the same time.

Time / Day

Date : 201704

Local Time Of Day : 0601-1200

Place

Locale Reference.ATC Facility : CCR.Tower

State Reference : CA

Environment

Flight Conditions : VMC

Light : Daylight

Aircraft : 1

Reference : X

ATC / Advisory.Tower : CCR

Aircraft Operator : Air Taxi

Make Model Name : EMB-505 / Phenom 300

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 135

Flight Plan : IFR

Mission : Passenger

Flight Phase : Initial Approach

Airspace.Class D : CCR

Aircraft : 2

ATC / Advisory.Tower : CCR

Make Model Name : Any Unknown or Unlisted Aircraft Manufacturer

Crew Size.Number Of Crew : 1

Airspace.Class D : CCR

Aircraft : 3

ATC / Advisory.Tower : CCR

Make Model Name : Helicopter

Crew Size.Number Of Crew : 1

Airspace.Class D : CCR

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Taxi

Function.Flight Crew : Captain

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Air Transport Pilot (ATP)

ASRS Report Number.Accession Number : 1442286

Human Factors : Confusion

Events

Anomaly.ATC Issue : All Types
Anomaly.Conflict : Airborne Conflict
Detector.Automation : Aircraft RA
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Took Evasive Action
Result.Flight Crew : Executed Go Around / Missed Approach
Result.Air Traffic Control : Issued New Clearance

Assessments

Contributing Factors / Situations : Airspace Structure
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Ambiguous

Narrative: 1

Approaching to land runway 19R at CCR. We were cleared for the visual approach. I was pilot flying. I was slightly high and fast on the approach. I was within 2 miles of the runway and fully configured to land. On very short final we received a TCAS RA and were advised to climb. I immediately followed the commands. By the time we were clear of the conflict I was not in a position to safely land. I called for and we began a go-around. We advised the tower that we were going around due to the traffic. The tower advised us to make right traffic. We climbed to 2500 feet (900 feet above pattern altitude) to avoid any GPWS warnings from the rising terrain west of the airport. We were established on the right downwind and were re-configuring to land when the tower seemed to get aggravated with us and ask us where we were going. We advised we were configuring to land on 19R. We began a turn toward a close in right base when we received a second RA this time on a helicopter that was aligning for another runway. Everything happened so fast with both RA's. I caught glimpses of both aircraft passing by and we were very close to both. The 1st closer than the second. We landed without further incident after clear of the second conflict. I was not asked to contact the tower so I didn't. The whole situation was very stressful and chaotic. Thank God for that TCAS. I was approached by a pilot in the FBO after we landed. He asked me if I was in the jet that just came in. He said to me "That was not your fault".

I have no idea where the aircraft came from on the first RA. We were advised about traffic when we first checked in with tower but that traffic was well to our west. We were cleared to land on short final when the RA traffic crossed right in front of us. On the second RA, I think we were told about that traffic but it was so close we still got the RA.

On the go-around we were flying a normal jet traffic pattern on a right downwind. While flying that pattern, the controller made a comment that we would have to cross the finals for the 14 runways. I was confused as to why he made that comment. He told us to fly right traffic. It seems obvious that we would have to cross those runways in order to land on 19R. He seemed annoyed about the traffic pattern that we were flying at one point asking us what our intentions were. At the time, we were concentrating on flying the airplane and avoiding all of the traffic that was showing on our TCAS.

Synopsis

EMB505 Captain reported two separate TCAS RA events while on visual approaches to Runway 19R at CCR.

Time / Day

Date : 201704

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : SNA.Airport

State Reference : CA

Altitude.MSL.Single Value : 2500

Aircraft : 1

Reference : X

ATC / Advisory.TRACON : SCT

Aircraft Operator : Military

Make Model Name : Helicopter

Flight Plan : VFR

Flight Phase : Cruise

Route In Use : None

Airspace.Class C : SNA

Aircraft : 2

Reference : Y

ATC / Advisory.TRACON : SCT

Make Model Name : Citation II S2/Bravo (C550)

Flight Plan : IFR

Flight Phase : Final Approach

Route In Use : Visual Approach

Airspace.Class C : SNA

Person

Reference : 1

Location Of Person.Facility : SCT.TRACON

Reporter Organization : Government

Function.Air Traffic Control : Supervisor / CIC

Qualification.Air Traffic Control : Fully Certified

Experience.Air Traffic Control.Time Certified In Pos 1 (yrs) : 5

ASRS Report Number.Accession Number : 1441548

Human Factors : Communication Breakdown

Human Factors : Confusion

Human Factors : Distraction

Human Factors : Fatigue

Human Factors : Situational Awareness

Human Factors : Troubleshooting

Human Factors : Workload

Human Factors : Human-Machine Interface

Communication Breakdown.Party1 : ATC

Communication Breakdown.Party2 : Flight Crew

Communication Breakdown.Party2 : ATC

Events

Anomaly.ATC Issue : All Types
Anomaly.Conflict : Airborne Conflict
Anomaly.Deviation - Procedural : Published Material / Policy
Anomaly.Inflight Event / Encounter : CFTT / CFIT
Detector.Person : Air Traffic Control
When Detected : In-flight

Assessments

Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Contributing Factors / Situations : Staffing
Primary Problem : Human Factors

Narrative: 1

I was on a control position for nearly an hour and 45 minutes then was told by the Controller in Charge (CIC) to take over his position. I now was CIC after a busy session on RADAR. I went around the room and made sure traffic was not an issue for the controllers. I asked the controller on Tustin if he was ok or needed a handoff or spacing from the Traffic Management Unit (TMU) because an average amount of IFR traffic was coming in. He declined. After about 10 min I heard this controller make comments that alerted me to a problem.

When I went to the sector I noticed the Citation making a left turn into an MVA and alerted the controller to it. I asked what was wrong and he said some issue with a VFR military helo not communicating near his arrival final to SNA. At that point I alerted him to another IFR arrival on final nearing the VFR helo; he tried to take action to turn the aircraft. He then said the Citation had an RA. I am not sure if the other aircraft involved had RA.

Staffing problems and no supervisors when needed. Controller should have asked for help earlier or resolved the potential conflict earlier before it became complex. Don't take a controller who has already been on a busy position off that one and make them CIC or to another position for that matter.

Synopsis

SCT TRACON Controller in Charge reported that another Controller was having separation problems with aircraft, was asked if he needed help and Controller denied help. Reporter stated staffing issues and no Supervisor in the area at the time.

Time / Day

Date : 201704

Local Time Of Day : 0601-1200

Place

Locale Reference.ATC Facility : SCT.TRACON

State Reference : CA

Altitude.MSL.Single Value : 2000

Environment

Light : Daylight

Aircraft

Reference : X

ATC / Advisory.TRACON : SCT

Aircraft Operator : Military

Make Model Name : Helicopter

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Flight Plan : IFR

Mission : Training

Flight Phase : Cruise

Route In Use : Vectors

Airspace.Class E : SCT

Person

Reference : 1

Location Of Person.Facility : SCT.TRACON

Reporter Organization : Government

Function.Air Traffic Control : Instructor

Function.Air Traffic Control : Approach

Qualification.Air Traffic Control : Fully Certified

Experience.Air Traffic Control.Time Certified In Pos 1 (yrs) : 18

ASRS Report Number.Accession Number : 1441525

Human Factors : Communication Breakdown

Human Factors : Distraction

Human Factors : Training / Qualification

Human Factors : Situational Awareness

Communication Breakdown.Party1 : ATC

Communication Breakdown.Party2 : ATC

Events

Anomaly.ATC Issue : All Types

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Inflight Event / Encounter : CFTT / CFIT

Detector.Person : Air Traffic Control

When Detected : In-flight

Result.Air Traffic Control : Issued Advisory / Alert

Assessments

Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Procedure

Primary Problem : Procedure

Narrative: 1

Aircraft X departed NZY for practice instrument approach at NZY. Training in progress. Trainee handed off Aircraft X to NZY Radar, but failed to effectively communicate transfer until aircraft reached a 2300 ft MVA.

Don't trust Trainee.

Synopsis

SCT TRACON Instructor reported the Developmental did not transfer communication to the Tower until the aircraft reached an area beneath the MVA.

Time / Day

Date : 201704

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : PNS.Airport

State Reference : FL

Altitude.AGL.Single Value : 1700

Environment

Flight Conditions : VMC

Light : Daylight

Aircraft : 1

Reference : X

ATC / Advisory.TRACON : P31

Aircraft Operator : Air Carrier

Make Model Name : MD-80 Series (DC-9-80) Undifferentiated or Other Model

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 121

Flight Plan : IFR

Nav In Use : FMS Or FMC

Flight Phase : Final Approach

Route In Use : Visual Approach

Airspace.Class E : P31

Aircraft : 2

Reference : Y

ATC / Advisory.TRACON : P31

Make Model Name : Bell Helicopter Textron Undifferentiated or Other Model

Flight Plan : VFR

Flight Phase : Final Approach

Airspace.Class C : PNS

Person

Reference : 1

Location Of Person.Facility : P31.TRACON

Reporter Organization : Government

Function.Air Traffic Control : Approach

Experience.Air Traffic Control.Time Certified In Pos 1 (mon) : 6

ASRS Report Number.Accession Number : 1439974

Human Factors : Distraction

Human Factors : Human-Machine Interface

Human Factors : Situational Awareness

Human Factors : Time Pressure

Human Factors : Workload

Human Factors : Communication Breakdown

Human Factors : Confusion

Human Factors : Troubleshooting

Communication Breakdown.Party1 : ATC
Communication Breakdown.Party2 : ATC

Events

Anomaly.ATC Issue : All Types
Anomaly.Conflict : Airborne Conflict
Anomaly.Deviation - Speed : All Types
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Person : Air Traffic Control
When Detected : In-flight
Result.Air Traffic Control : Issued Advisory / Alert
Result.Air Traffic Control : Separated Traffic

Assessments

Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Procedure

Narrative: 1

I relieved a trainer and trainee but was unsure of how their plan would work with a 100 knot overtake and 5 miles closing to 3 between an MD80 and a Bell Helicopter. I was asking questions expecting a post overlap briefing but the trainer left the position. Tower called to ask if they needed to turn out the helo on a practice approach in VFR conditions was being overtaken by 100 knots and I said yes turn him out now. Tower waited for a mile or so because they had traffic in their pattern. The helo finally turned out on what appeared to be a 010 heading instead of a 080 heading as he was assigned. I think the wind was a factor. He appeared to be head on with the MD80 and I asked the helo to level off at 800 feet which is below the MVA of 1700 feet.

I did this to avoid a collision with the MD80 and the helo. I am filing this report because I felt by asking the helo to level off at 800 feet for a couple seconds in his departure climb that it would avoid a collision with an MD80. I don't understand why the FAA no longer requires an overlap from a controller giving another controller a briefing to assume the position they have been working. I also will not take on a situation with an impending separation error again and instead let the controller work out their plan whatever that is, then assume the position after all separation errors have been resolved.

Bring back the post 2 minute briefing and don't expect controllers to immediately assume a position just because it's time for the current controllers break. 5 minutes can make a huge difference in an imminent situation that the current controller is much more familiar with as well as has already executed whatever plan was in their mind.

Synopsis

P31 TRACON Controller reported an unsafe situation where a jet overtook a helicopter on final.

Time / Day

Date : 201704

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Environment

Flight Conditions : Marginal

Aircraft

Reference : X

Aircraft Operator : Air Taxi

Make Model Name : Helicopter

Operating Under FAR Part : Part 121

Mission : Ambulance

Flight Phase : Cruise

Component

Aircraft Component : Fuel Quantity-Pressure Indication

Aircraft Reference : X

Problem : Malfunctioning

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Taxi

Function.Flight Crew : Pilot Flying

Function.Flight Crew : Captain

Qualification.Flight Crew : Commercial

ASRS Report Number.Accession Number : 1439512

Human Factors : Situational Awareness

Human Factors : Training / Qualification

Events

Anomaly.Aircraft Equipment Problem : Less Severe

Anomaly.Inflight Event / Encounter : Fuel Issue

Detector.Person : Flight Crew

When Detected : In-flight

Result.General : Maintenance Action

Assessments

Contributing Factors / Situations : Aircraft

Contributing Factors / Situations : Equipment / Tooling

Contributing Factors / Situations : Human Factors

Primary Problem : Equipment / Tooling

Narrative: 1

My crew had started the mission via ground ambulance. I accepted the flight and needed to put on fuel prior to departing for the mission so I would have enough fuel to complete the mission. Prior to this I had [the aircraft] topped off for the flight back to base. Once landing at base, the aircraft did not fly again until Friday night when I accepted this mission. Upon accepting the mission I repositioned to the fuel farm to put on fuel. At this time I put on 51 Gallons Jet A fuel and then departed.

Just over halfway into the flight I got a Master Caution indicating a Fuel Quantity Degraded and the Main fuel Tank was fluctuating by 50 to 100 KG's. At this point in the flight I was the closest to the hospital and continued to land there. When I went to turn final I received another Master Caution light indicating that I had a Fuel Quantity Failure on the Main tank and proceeded to land.

Upon landing I called the on duty Mechanic and pulled out the MEL book to see if we could MEL it. The mechanic then called his supervisor and was given the go ahead to MEL the aircraft. The plan was for me to drop the patient off and then stop to top off fuel and then fly to ZZZ to have the aircraft fixed. On the patient flight my number 2 supply tank went offline about 5 min from the pad. Just before landing the number 1 supply tank indication also went away. I landed and dropped the patient and then flew to the fuel stop and landed. Called the Mechanic and told him what happened and then they decided to come to check the aircraft. While draining the fuel from the aircraft found water and other large debris in the fuel. The fuel was also cloudy and very brown in color.

Synopsis

Helicopter Captain reported fuel quantity failures on a multi-leg patient flight which was later determined by Maintenance to be caused by contaminated fuel.

Time / Day

Date : 201704

Local Time Of Day : 1201-1800

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.MSL.Single Value : 500

Environment

Flight Conditions : VMC

Weather Elements / Visibility.Visibility : 10

Light : Daylight

Ceiling.Single Value : 10000

Aircraft

Reference : X

ATC / Advisory.Tower : ZZZ

Aircraft Operator : FBO

Make Model Name : Robinson R22

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 91

Flight Plan : VFR

Mission : Training

Nav In Use : GPS

Flight Phase : Cruise

Route In Use : Direct

Airspace.Class D : ZZZ

Airspace.Class G : ZZZ

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : FBO

Function.Flight Crew : Instructor

Function.Flight Crew : Pilot Flying

Qualification.Flight Crew : Flight Instructor

Qualification.Flight Crew : Commercial

Experience.Flight Crew.Total : 2240

Experience.Flight Crew.Last 90 Days : 10

Experience.Flight Crew.Type : 1000

ASRS Report Number.Accession Number : 1439008

Human Factors : Situational Awareness

Events

Anomaly.Airspace Violation : All Types

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Deviation - Procedural : FAR

Detector.Person : Flight Crew
When Detected : In-flight
Result.General : Police / Security Involved
Result.Air Traffic Control : Provided Assistance

Assessments

Contributing Factors / Situations : Airspace Structure
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Procedure
Primary Problem : Airspace Structure

Narrative: 1

Was enroute to ZZZ, with thoroughly prepared flight plan using FAA approved software Foreflight. All area maps and software were current and reporting all active and inactive TFRs within state area. However, this TFR was not listed or declared as active. ZZZ Tower contacted us while refueling at their facility, providing us with a number to contact. We asked ZZZ Tower if we were clear to proceed on our flight, and they confirmed that we were. Shortly after we contacted ZZZ1 tower to be cleared into their airspace, which we were, but were instructed to contact approach. We contacted approach, and were cleared to proceed on our declared flight path, but were told to divert northbound to accommodate an inbound plane.

After we cleared the inbound plane, they instructed us to proceed on our path, and contact Tower. We contacted ZZZ1 Tower, and were told to return to ZZZ1 airport on the helipad, and were provided the approach number to contact once we landed. We followed instructions, contacted approach upon landing, and were instructed to go inside the FBO, because someone wanted to speak with us. Federal Agents interviewed myself, and the student pilot, and asked why we had busted the TFR. We immediately showed them our flight charts on Foreflight, which listed no such active TFR. They understood at that point that we had done our research, and were not imposing a threat, and had not caused an issue, and dismissed us both.

Synopsis

R22 instructor pilot reported that after landing they were asked to meet with Federal officials for busting a TFR.

Time / Day

Date : 201703

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 0

Environment

Flight Conditions : VMC

Weather Elements / Visibility.Visibility : 10

Light : Night

Ceiling.Single Value : 10000

Aircraft : 1

Reference : X

ATC / Advisory.CTAF : ZZZ

Aircraft Operator : Personal

Make Model Name : Skylane 182/RG Turbo Skylane/RG

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 91

Mission : Personal

Flight Phase : Initial Climb

Route In Use : Direct

Airspace.Class G : ZZZ

Aircraft : 2

Reference : Y

ATC / Advisory.CTAF : ZZZ

Aircraft Operator : Military

Make Model Name : Chinook (CH-47)

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Mission : Training

Flight Phase : Taxi

Aircraft : 3

Reference : Z

ATC / Advisory.CTAF : ZZZ

Aircraft Operator : Military

Make Model Name : Chinook (CH-47)

Crew Size.Number Of Crew : 2

Operating Under FAR Part : Part 91

Mission : Training

Flight Phase : Climb

Airspace.Class G : ZZZ

Person

Reference : 1
Location Of Person.Aircraft : X
Location In Aircraft : Flight Deck
Reporter Organization : Personal
Function.Flight Crew : Single Pilot
Qualification.Flight Crew : Private
Experience.Flight Crew.Total : 970
Experience.Flight Crew.Last 90 Days : 20
Experience.Flight Crew.Type : 800
ASRS Report Number.Accession Number : 1437354
Human Factors : Communication Breakdown
Communication Breakdown.Party1 : Flight Crew
Communication Breakdown.Party2 : Flight Crew

Events

Anomaly.Conflict : Ground Conflict, Critical
Anomaly.Deviation - Procedural : Published Material / Policy
Detector.Person : Observer
When Detected : In-flight
Result.General : None Reported / Taken

Assessments

Contributing Factors / Situations : Airport
Contributing Factors / Situations : Airspace Structure
Contributing Factors / Situations : Human Factors
Primary Problem : Human Factors

Narrative: 1

I landed at ZZZ to offload a passenger, who is also a pilot. As I was landing I heard a CH-47 (Helicopter Number 1) declare his intentions to land at ZZZ. I taxied to the ramp, and offloaded my passenger. I then taxied back to the end of Runway XX for departure to ZZZ1. As I was taxiing I heard a second CH-47 (Helicopter Number 2) declare his intentions to do a low approach to Runway XX at ZZZ. I was in constant communication with Number 2 sending and receiving our respective intentions. Number 2 made his low approach and I watched him make a standard pattern departure. There was no communication with Number 1 and it was my understanding he had departed ZZZ. I performed my normal preflight checklist and as Number 2 turned downwind for Runway XX I announced my intentions to take off on Runway XX and notified Number 2 that I had him insight and would pass well behind him. It should be noted that there is no line of sight between runway ends. I took off and made a normal pattern departure with Number 2 insight at all times and then turned direct ZZZ1.

After landing at ZZZ1 my passenger called from ZZZ very concerned and informed me that I had flown over helicopter Number 1 and it was possible that he was still on the runway. At no time during taxi, takeoff or pattern departure did I have any visual on Number 1 and Number 1 never acknowledged any of my radio call regarding taxiing or takeoff and his position at the airport. It is possible that I could not see his beacon due to the grade of the runway and the position of the helicopter. Number 2 responded to every radio call as I did his. After discussing the event my passenger we concluded that it was very likely that part of helicopter Number 1 was either very close to or over the hold short line at the exit at the very end of Runway XX. To add to the my belief that Number 1 had departed there was a star/planet that was very bright directly of the approach end of Runway XX that I

believed was helicopter Number 1 making a second approach to ZZZ. In the future I will make a dedicated effort confirm the position of any second aircraft and especially a flight of 2 prior to entering a runway and taking off. I could have asked Number 2 if he knew the position of the other aircraft.

Synopsis

C182 pilot reported that during takeoff at a non-towered airport he flew over a helicopter that was at the end of the runway.

Time / Day

Date : 201703

Local Time Of Day : 1201-1800

Place

Locale Reference.ATC Facility : R90.TRACON

State Reference : NE

Altitude.MSL.Single Value : 2600

Aircraft

Reference : X

ATC / Advisory.CTAF : OMA

Make Model Name : EC135

Flight Plan : IFR

Flight Phase : Initial Climb

Route In Use : None

Airspace.Class E : OMA

Person

Reference : 1

Location Of Person.Facility : R90.TRACON

Reporter Organization : Government

Function.Air Traffic Control : Departure

Function.Air Traffic Control : Approach

Qualification.Air Traffic Control : Fully Certified

Experience.Air Traffic Control.Time Certified In Pos 1 (yrs) : 23

ASRS Report Number.Accession Number : 1435156

Human Factors : Communication Breakdown

Human Factors : Confusion

Human Factors : Human-Machine Interface

Human Factors : Situational Awareness

Human Factors : Distraction

Communication Breakdown.Party1 : ATC

Communication Breakdown.Party2 : ATC

Events

Anomaly.Airspace Violation : All Types

Anomaly.ATC Issue : All Types

Anomaly.Deviation - Procedural : Published Material / Policy

Anomaly.Deviation - Procedural : Clearance

Detector.Person : Air Traffic Control

When Detected : In-flight

Result.Air Traffic Control : Separated Traffic

Assessments

Contributing Factors / Situations : Human Factors

Contributing Factors / Situations : Procedure

Primary Problem : Procedure

Narrative: 1

Aircraft X called departing Helipad North of the hospital in MVFR conditions. The pilot advised me that he was on an IFR clearance that was issued by Omaha Clearance Delivery. No coordination occurred from Omaha Tower to me. The helicopter was inside the 3500' MVA ring when I saw a splat for his target but no data tag. I asked the Controller in Charge (CIC) and the R90 Flight Data if they knew anything about this or had done any coordination and what I was expected to do with the helicopter. The controller I had relieved had just pushed a strip over for the aircraft after the recorded briefing was over and mentioned that the helicopter strip was already printed and laying at the Radar West position and that the helicopter was at [an adjacent airport] airport and Local would "flash" the tag when the helicopter departed [the adjacent airport]. The strip showed the aircraft filed for 4000' MSL. There was no departure tag in my departure list, so I RF'd the squawk code and then the tag showed up on the helicopter as he tracked South away from the antennas. I had the helicopter ident. I radar identified the helicopter and told him to climb and maintain 4000' and sent him on his way to [the destination], issuing current altimeter and verifying his altitude. I continued working my other traffic and handed the helicopter off to center and transferred communications to ZMP sec. 26. I had no further communications with the helicopter.

It is apparent that Clearance Delivery (CD) at OMA issued a clearance without knowing where the helicopter was actually located.

Clearance Delivery needs to ensure where an aircraft/helicopter is located before issuing a clearance and in this instance if a HFR [Hold For Release] had been issued to the pilot, he would not have departed without obtaining a release at which point somebody would have had to know where the helicopter was positioned. If the CD person had told the pilot to contact GC when ready to taxi, this would have brought up the opportunity for the pilot to point out he wouldn't be taxiing as he was not at the airport. Easiest thing to do is verify the position of an aircraft before issuing a clearance.

Synopsis

Omaha TRACON Controller reported that an IFR aircraft departed on an IFR clearance without being properly released into the airspace.

Time / Day

Date : 201703

Local Time Of Day : 0601-1200

Place

Locale Reference.Airport : STS.Airport

State Reference : CA

Altitude.MSL.Single Value : 400

Environment

Flight Conditions : IMC

Weather Elements / Visibility : Fog

Weather Elements / Visibility.Visibility : 2

Light : Daylight

Ceiling.Single Value : 300

RVR.Single Value : 500

Aircraft

Reference : X

ATC / Advisory.Tower : STS

Aircraft Operator : Personal

Make Model Name : Helicopter

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 91

Flight Plan : VFR

Mission : Personal

Flight Phase : Cruise

Route In Use : Direct

Airspace.Class D : STS

Component

Aircraft Component : GPS & Other Satellite Navigation

Aircraft Reference : X

Problem : Malfunctioning

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Personal

Function.Flight Crew : Pilot Flying

Function.Flight Crew : Single Pilot

Qualification.Flight Crew : Commercial

Qualification.Flight Crew : Rotorcraft

Experience.Flight Crew.Total : 600

Experience.Flight Crew.Last 90 Days : 30

Experience.Flight Crew.Type : 180

ASRS Report Number.Accession Number : 1433926

Human Factors : Workload

Human Factors : Confusion
Human Factors : Human-Machine Interface
Human Factors : Situational Awareness

Events

Anomaly.Aircraft Equipment Problem : Less Severe
Anomaly.Airspace Violation : All Types
Anomaly.Deviation - Track / Heading : All Types
Anomaly.Deviation - Procedural : Clearance
Detector.Person : Air Traffic Control
When Detected : In-flight
Result.Flight Crew : Became Reoriented
Result.Flight Crew : Exited Penetrated Airspace
Result.Flight Crew : FLC complied w / Automation / Advisory
Result.Air Traffic Control : Issued New Clearance
Result.Air Traffic Control : Issued Advisory / Alert

Assessments

Contributing Factors / Situations : Aircraft
Contributing Factors / Situations : Human Factors
Contributing Factors / Situations : Weather
Primary Problem : Aircraft

Narrative: 1

GPS accuracy issue. I was notified I had appeared in the airspace of STS during IFR/IMC, and was asked to leave which I did promptly.

Synopsis

Helicopter pilot reported mistakenly flying into STS Class D airspace due to a GPS accuracy error.

Time / Day

Date : 201703

Local Time Of Day : 1801-2400

Place

Locale Reference.Airport : ZZZ.Airport

State Reference : US

Altitude.AGL.Single Value : 1000

Environment

Flight Conditions : VMC

Weather Elements / Visibility.Visibility : 10

Light : Night

Aircraft

Reference : X

ATC / Advisory.CTAF : ZZZ

Aircraft Operator : Air Taxi

Make Model Name : Jet Ranger All Series Undifferentiated or Other Model

Crew Size.Number Of Crew : 1

Operating Under FAR Part : Part 91

Flight Plan : VFR

Mission : Ferry

Flight Phase : Cruise

Route In Use : Visual Approach

Airspace.Class E : ZZZ

Component

Aircraft Component : Turbine Engine

Aircraft Reference : X

Problem : Malfunctioning

Person

Reference : 1

Location Of Person.Aircraft : X

Location In Aircraft : Flight Deck

Reporter Organization : Air Taxi

Function.Flight Crew : Pilot Flying

Function.Flight Crew : Single Pilot

Qualification.Flight Crew : Rotorcraft

Qualification.Flight Crew : Commercial

Qualification.Flight Crew : Instrument

Experience.Flight Crew.Total : 2600

Experience.Flight Crew.Last 90 Days : 50

Experience.Flight Crew.Type : 50

ASRS Report Number.Accession Number : 1433231

Events

Anomaly.Aircraft Equipment Problem : Critical
Detector.Person : Flight Crew
When Detected : In-flight
Result.Flight Crew : Landed As Precaution

Assessments

Contributing Factors / Situations : Aircraft
Primary Problem : Aircraft

Narrative: 1

Engine chip light illuminated under normal cruise flight power settings for ambient conditions causing the pilot to land as soon as possible without incident. No exceedances had previously been recorded on the Rolls-Royce turbine engine and it had met all periodic maintenance requirements. Post flight inspection of the 2 engine chip detectors revealed extensive metal chips resulting in engine replacement. To prevent a recurrence the root cause of the engine chips should be investigated/current maintenance schedule should be evaluated.

Synopsis

Bell 407 pilot reported landing as soon as possible after receiving an engine chip light in cruise flight.