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AIR BEAT

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HUMAN FACTORS & SAFETY

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On the cover: A California Highway Patrol Air Operations Unit helicopter lands on the heli-pad at the Los Angeles (CA) Police Department Air Support Division-hosted Annual Chili Fly-In 2015. Courtesy Eric Jensen.

Above: Courtesy of Eric Jensen.

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PRESIDENT
Steve Roussell

Air Beat traditionally puts an emphasis on safety as we enter each New Year. It's a metaphorical fresh start to incidents and accidents, a mindset driven largely by the Federal Aviation Administration and National Transportation Safety Board's statistical accounting for such things. But let us not forget the impact of our industry's prior incidents and accidents. Let's not forget the lessons learned from prior mistakes or those people tragically affected when threat and error management fails.

As we begin 2016, let's each make a conscious effort to improve safety, a sort of New Year's resolution to improve the safety culture wherever you work. I implore each of you to find at least one common practice of your unit that everyone knows is contrary to established safety practices and simply bring it up at your next briefing. I ask each of you to identify at least one latent condition in your workplace and address it. If you have never heard the term "latent condition" or if you have never had formal training on identifying latent conditions, I beg of you to attend an aviation safety class near you. If a safety class does not exist near you or travelling is limited by finance or policy within your unit, call me or e-mail me or send smoke signals. ALEA will bring one to you. It truly is that important.

Steve



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FROM YOUR ALEA EXECUTIVE DIRECTOR/CEO

Last year at this time, I was informing you of NTSB's decision to include public safety helicopter operations on their 2015 10 Most Wanted List, and what ALEA was doing to address it. I ended my message by stating that our focus would continue to be on providing industry-leading education and training programs for the safe and successful completion of each airborne public safety operation, and that this, coupled with your efforts to provide the safest possible public safety aviation operations to your respective communities, is the best way to demonstrate to NTSB our displeasure with their targeting of public helicopter operations and to ensure that we are not on this or any other "most wanted" list in the future. I am happy to report that our collective efforts have paid off as our industry was not singled out in the 2016 list. Congratulations. However, that's not to say that there still isn't work to do. One of the areas on which NTSB is focusing in 2016 is the reduction of fatigue-related accidents. As the shift work and extra employment that many of us are involved in makes us prone to fatigue, this should be an area of focus for ALEA as well. The NTSB notes that combating fatigue requires a comprehensive approach focused on research, education and training, technologies, treatment of sleep disorders, hours-of-service regulations, and on-and-off duty scheduling policies and practices. We have a great team in place, Training Program Manager Don Roby, Safety Program Manager Bryan Smith and ALEA Aeromedical Liaison Dudley Crosson, to address the education and training and research components of their recommendation. If your agency and/or unit has hours-of-service and on-and-off duty scheduling policies, now would be a good time to review them. And if they don't, now is an excellent time to create and institute them.

A couple of other areas in NTSB's 2016 list that may impact our operations are the strengthening of occupant protection systems and the expanding the use of recorders to enhance safety. In regards to occupant protection, I applied and was chosen to serve on FAA's Aviation Rulemaking Advisory Committee (ARAC) Rotorcraft Occupant Protection Working Group (ROPWG), representing ALEA and public safety aviation. The focus of this group will be crash-resistant seat systems and fuel tanks. Any decision to retroactively enforce any action regarding these seat systems and/or fuel tanks could have a major impact on our operations. I will keep you informed.

I want to recognize the combined efforts of Bryan Smith and Don Roby, as well as all of you. Through focusing on IIMC and wire strikes through our safety and training programs, and through your awareness and execution, public safety aviation did not experience a single accident attributed to either of these in 2015. Keep up the good work; however, don't let our recent success in these areas lead to complacency in your operations.

One of my favorite quotes from Colin Powell is, "If you are going to achieve excellence in big things, you develop the habit in little matters. Excellence is not an exception, it is a prevailing attitude." I like to apply this to safety. It's the little things we do each day (pick up FOD, fill out a safety hazard report, use a checklist, wipe up drops of oil, complete a FRAT, etc.) that make safety the prevailing attitude in our operations. And through that prevailing attitude, we achieve excellence. Here's to a safe and productive 2016.



EXECUTIVE DIRECTOR/CEO

Daniel B. Schwarzbach

Dan



CONQUER

HAZARDS, TAME

RISKS

Likelihood

Unlikely
Might

Low Risk
(Acceptable)

Medium Risk

High Risk

Low Risk
(Acceptable)

Low Risk
(Acceptable)

Medium Risk

Low

Medium

High

Impact

By **Matt Johnson**, FAA Designated Pilot Examiner, FAASTeam Rep and member of the United States Helicopter Safety Team Human Factors Working Group

There are many definitions for the word “hazard.” One such definition says a hazard is a present condition or circumstance that could lead to or contribute to an unplanned or undesired event such as an accident. What is often overlooked and misunderstood is that many aviation risks are born of hazardous conditions (and attitudes) that are the result of cultural acceptance over time.

Operational mindsets regarding airborne law enforcement missions often involve ideas like, “that’s the way we do it,” “that’s how we have always done it” or “we have got to get this done.” Organizational inadequacies such as these have given birth to many unidentified and unnecessary risks and numerous fatal accidents. Many organizations operating under this mentality don’t know what the right way to do things looks like.

As the old saying goes, ignorance is bliss. In many instances, organizations operating with incorrect mission mindsets only learn what is right after an accident or incident has occurred and everything has been brought to the forefront, normally through an investigative body or in the form of an outside audit. These are the organizations that say, “We haven’t had an accident in 20-plus years; we obviously are doing things right.” Typically, it is only by the grace of God that circumstances didn’t line up to produce a catastrophic accident for these organizations.

LOOK FOR HAZARDS

All risks cannot be eliminated; however, many of the risks we face in our industry can be eliminated with the identification and conquering of organizational hazards. You don’t know what you don’t know, and the way to educate yourself about the hazards within your organization involves work, time and serious commitment.

Organizations must seek out the things it does not know. The goal is to avoid dangerous situations, find hazards and neutralize the threat they pose before they cause a problem.

Fortunately, much of the work has already been done and readily available. It’s up to your organization to seek out the resources and utilize them in your operations. In a perfect world with a workable budget, a good place to start is with an outside analysis. This will give the organization an idea of what hazards are present and, more importantly, how to mitigate those hazards. While most have absolutely no desire to have an outsider look at their

organization, the function of an external audit is to ensure internal controls, processes, guidelines and policies are not only adequate and effective, but also in compliance with industry standards and social expectations.

The basic question asked by a good audit is, “are you doing everything possible to keep your people and equipment safe?” A proper audit will identify the hazards and subsequent risks to which the organization is blind.

NEUTRALIZE HAZARDS

For nearly all facets of our industry, an organization can find a set of best practices to adopt. While you may not agree with all of the recommended practices, most have a great deal of merit and warrant a serious look. For airborne law enforcement operations, the Standards for Law Enforcement Aviation Units developed by the Public Safety Aviation Accreditation Commission is an excellent starting point

to see where your organization falls compared to units employing industry best practices.

One example of an extremely effective best practice not being utilized industry wide is the flight risk assessment tool (FRAT). In the air medical industry, FRATs are not only utilized, but also mandated, by regulation. Yet some law enforcement organizations still don’t know they exist. If they have heard of them, they often decide they are too small of a unit to use them. No unit is too small to sit down and collectively weigh the risks involved in a particular flight or shift. Not doing so is negligent.

Is it possible to conquer all hazards? Not likely. But each hazard airborne law enforcement units face can be effectively mitigated if the organizations know of its existence and how to attack it. Failing to make an effort to find out what you don’t know about your organization could be the first ingredient in a recipe for disaster. Standards and industry best practices are available. Seek them out. 🏆

