

# Lessons Learned

Sharing problems encountered while flying  
can help others avoid the same pitfalls.

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I am sure the ghostly, terror-stricken look on the face of the pilot was a reflection of my own facial expression. And even though there were no words exchanged at that particular moment, the message came through loud and clear to both of us—we'd never try that foolish stunt again!

As with so many flights ending in an accident or near miss, this particular mission, a Functional Check Flight (FCF), contained a cleverly concealed ingredient for disaster. You see, this particular FCF profile included a procedure that wasn't exactly covered in the flight manual. Instead, it fell into the unquestioned category of "That's the way we've always done it," and the procedure had been guaranteed flawless during past FCF flights. I'm sure the reason for the lumps in our throats was obvious when the pilot and I found our *flawless* procedure had placed our helicopter into that dangerous situation known as settling with power. Quickly developing the aerodynamic characteristics of a rock, the chopper lost altitude faster than we could have ever imagined. And even though we recovered safely, the fact we did so at an altitude where we were looking up at nearby 50-foot

telephone poles was far from comforting.

Back at our unit, as a newly minted copilot, I naively expected the details of our FCF incident to be passed on to the other pilots. Several weeks and a couple of pilot meetings later, however, there was still no word being spread about our incident. This all began to leave a bad taste in my mouth as my mild fears about admitting our mistake were overcome by questions: First, what's going to happen the next time that "guaranteed" FCF procedure is performed? Second, why won't the pilot or even his inexperienced copilot say something to warn others? After one of those behind closed door sessions, I had at least a partial answer to my second question. It was made very clear to me that you did not discuss your mistakes in the presence of the unit's hierarchy. And even worse, your (then) controlled OER and career were at stake everytime you opened your mouth, or so most of the pilots thought.

Good grief, I wondered later, what kind of price would we have to pay that could be worse than the possible loss of a crew and their aircraft? A bit of confessing and a momentary loss of pride was all the pilot and I had

at stake. Yet, our FCF incident remained one of the best kept secrets in the Air Force.

On the other side of the coin, the younger pilot's fears of unfavorable repercussions in return for their honesty may have had some basis in the way things were run in the unit. Pilot meetings were often a one-way street where standardization and safety would preach and those of us in need of salvation would listen. Audience participation was rarely offered or solicited. I never saw anyone give the *honest* approach a fair shot.

As many a brash young pilot had done in the past, I made all sorts of promises to myself that I would change this unhealthy situation. Someday, in a position of authority, I would pass on what I saw to all who would listen; damn my career, full speed ahead! A short time later, my new-found ideals were put to the test.

Our unit frequently supported the local civilian community hospitals with a helicopter medical evacuation service. Many of these flights were routinely made to roof-top helipads at the various hospitals. One warm summer day three years ago, we landed at one of these pads and picked up a heavier-than-normal load of

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medical specialists and their equipment. Often, the pilots in our unit only concerned themselves with the helicopter's ability to hover on its own cushion of air at a four-foot height above the hospital pad. With most of the pilots in the unit at that time being new to the rotary-wing world, little thought was given to what could happen when we lost that cushion of air as we passed over the edge of the hospital at slow takeoff speeds. For those of you unfamiliar with a helicopter, its ability to hover out of its own cushion of air is in part limited by the power the aircraft's engines are capable of producing under various conditions. This fact was never more apparent than at the precise moment the aircraft commander eased our helicopter off the hospital pad and out over the city several hundred feet below. Even using 100% power, we were rapidly losing altitude. Fortunately, the AC was one of those old heads who stopped counting his flying time well into the thousands of hours. He managed to fly us out of the descent, but not before we were looking up at the tree tops in the hospital parking lot.

Returning to the unit, this earnest young co-pilot timidly crept into our standardization office and quietly told all. To my surprise, downgrade action was not the order of the day. Instead, our chief of standardization was delighted to have someone come forward and share the lessons they had learned. At the next pilot's meeting, the spotlight was on me and my most recent experience. A lively discussion involving all of the aircrew members followed, and the outcome was a religiously followed practice of frequently reviewing the problems associ-

ated with operating from rooftop helipads.

Approximately three years have passed since that incident, and I have gained much more flying experience and the title of flight examiner. Even so, I still manage to make mistakes. Quite a few of them in fact! But what of the promises I made to myself three years ago; have they fallen by the wayside along with my many New Year's Resolutions? No, not really. To keep the atmosphere of honesty alive, I most recently subjected myself to the scrutiny of our aircrews and discussed a lesson I learned from a very foolish mistake made on one of my flights. I'd be kidding you if I said everything about that discussion was perfect; some of the diehards from the old school of thought cringed in their seats as I made my confession. But in general, the ice has remained broken. Our unit's aircrews are developing the attitude that "if a flight examiner can admit his mistakes in public, and it doesn't seem to have wreaked havoc on his career, then maybe I should relate what happened to me on my last 'exciting' flight."

All too often we forget that to err is human, and in our own minds we either expect to receive, or plan to dish out, the worst measure of punishment for a single mistake. My own experience under several supervisors has shown that in reality just the opposite generally occurs. If you cannot honestly say that the aircrew members in your unit can share their experiences freely, face the facts: We're all going to make mistakes—with some of them falling into the real bonehead category. However, as supervisors, standardization types, pilots, and aircrew members in

general, we may be setting ourselves up for disaster on our very next flight if we fail to encourage the sharing of lessons learned. ✈

*MAC crewmembers have many opportunities to anonymously admit their mistakes publicly so that everybody can learn from them. The USAF Hazard Report, "There I Was" program, Hazardous Air Traffic Report, and NASA's Aviation Safety Reporting System [ASRS] are some of them. The Flyer also publishes a special feature, "Flyers Anonymous," for the purpose of anonymously sharing lessons learned.—Ed*



#### ABOUT THE AUTHOR

Captain Hicks was commissioned through the AFROTC program at Indiana University. He accepted an educational delay, earning a master's degree from Newark College of Engineering, and subsequently entered Undergraduate Helicopter Flight Training at Fort Rucker, Alabama. After receiving his wings, he attended advanced helicopter training at Kirtland AFB, New Mexico. From there, he was assigned to Fairchild AFB, Washington where he is currently a Flight Examiner in the UH-1N.