Occurrence Report - Helicopter and Agricultural Aviation Operators

The purpose of submitting occurrence information and information derived from safety investigations is to improve aviation safety. The data from these reports are critical to determining areas of risk, monitoring trends over time and - most importantly - learning how to reduce the risk of accidents occurring. This form has been developed in collaboration with the NZHA and NZAAA and is designed specifically for the helicopter and agricultural aviation sectors. Its purpose it to collect the information important to safety in these sectors, and to assist operators in determining the causal factors behind occurrences so that lessons can be learned.

PLEASE EMAIL AN ATTACHMENT OF COMPLETED FORM TO: ca005@caa.govt.nz

Occurrence Date　　Time　　Location　　Aircraft Reg ZK -

Aircraft make/model　　Operator Name　　Client ID

POB　　Nil Injuries　　Injuries Fatal (Crew / PAX)　　Injuries Serious (Crew / PAX)　　Injuries Minor (Crew / PAX)

Operational Details

Departure Point　　Destination Point　　VFR　　IFR　　VMC　　IMC

Nature of flight

Passenger A to A	Passenger A to B	Agricultural	Other aerial work
Training dual	Training solo	Ferry/positioning	Test
Air ambulance	Other		

Flight phase

Parked	Taxi/hover taxi	Takeoff	Climb
Hover	Ferry/cruise	Circuit	Descent
Approach	Landing	Other	

Effect on flight

Nil	Aborted takeoff	Failure to get airborne	Emergency landing
Missed approach	Turnback	Engine(s) shutdown	Loss of control/performance
Avoiding action	Abnormal landing	Other	

Description of the Occurrence - please provide an account of what took place

PIC name　　Licence #　　Hours last 90 days　　Hours on type　　Hours total

Nature of Occurrence

Collision/strike object	Passenger/cargo related occurrence	Loss of control
Fuel/fluids occurrence	Component or system failure or malfunction	Engine power loss
External load	Airframe/equipment failure　　Other	

"Every major accident has precursors that might have been used to predict the event" - Nancy Leveson

Aircraft defect/Engineering details	Component/system affected		Part defective

ATA code | Manufacturer | Model | Part no | Serial no

TTIS hours | Cycles | TSO hours | Cycles | TSI hours | Cycles

Maintenance organisation | Client ID

Aircraft damage level | Destroyed | Substantial | Minor | Other

Engineering Description of Occurrence

Causes of the Occurrence

This section of the report is designed to assist in determining the causes of the occurrence. The categories of causal factors have been developed based on analysis of helicopter and agricultural accidents conducted by the NZHA and AAA. They are the ones that most commonly underpin accidents and incidents in these sectors. Please review each of the four categories of causation below against what took place, and indicate which factors applied. This should give you a good understanding of what caused it: use this understanding to complete the 'lessons learned' section at the end of the report.

1: Human Factors - please indicate if any of the factors below may have contributed to the occurrence

Decision making	Situation awareness	Flight/mission planning	Communication
Operating experience	Training	Complacency	Flight discipline
Distraction	Other:		

Comment/notes on how human factors may have contributed to the occurrence:

2: Operating Environment - please indicate if any of the factors below may have contributed to the occurrence

Wind level/direction	Turbulence	Light level	Sunstrike
Cloud	Rain/drizzle	Low-level hazards (e.g.wires, trees, poles, etc.)	
Airstrip conditions	Snow/ice	Uneven terrain	

Other:

Comment/notes on how operating environment factors may have contributed to the occurrence:

3: Mechanical/Equipment - please indicate if any of the systems/equipment below contributed to the occurrence

Powerplant | Airframe | Rotor systems | Fuel/fluid systems

Flight controls | Instruments | Spray gear/sling/other role equipment

Other:

Comment/notes on how mechanical/equipment factors may have contributed to the occurrence:

4: Organisational and Regulatory - please indicate if any of the factors below may have contributed to the occurrence

Company SOPs | Training policies | Maintenance procedures | Sector/industry culture

CAA rules & regulations | Other:

Comment/notes on how organisational and regulatory factors may have contributed to the occurrence:

Lessons Learned - what advice would you give to another similar operator to reduce their chances of something like this happening to them?

THANK YOU. PLEASE EMAIL A COPY OF THIS REPORT TO ca005@caa.govt.nz

"Progress on safety can be made by understanding how people create safety and by understanding how the creation of safety can break down in resource-limited systems that pursue multiple competing goals" - S. Dekker