

The Concern Network shares verified information to alert medical transport programs when an accident/incident has occurred. Both air and ground programs are encouraged to participate. If you have questions, contact CONCERN Coordinator David Kearns at (800) 525 3712 or www.concern-network.org.

November 22, 2008

The following incident occurred to St. Mary's LifeFlight. A maintenance check of the air filter system was being performed on the Bell 407 on the helipad at the sponsoring hospital. The aircraft was plugged into the GPU by the mechanic and then the pilot started the aircraft, ran through the checklist, and signaled for the mechanic to unplug the GPU. The mechanic unplugged the GPU and got into the back of the aircraft, where it was lifted into a hover to complete the test. When they did not get the results they were looking for, the aircraft landed, was shut down, and additional adjustments were made.

On the second start, the aircraft again was plugged into the GPU and started normally, but this time, the mechanic walked around to the pilot's side door to watch the start, which was again normal, and then climbed in the back of the aircraft while the pilot finished the checklist. They then lifted into a hover to again check the filter status. It was not until the aircraft had landed that they both realized that the GPU had still been plugged in when they picked up into a hover.

In debriefing this incident, the pilot stated that he got out of his normal routine as he was working with the mechanic during the startup procedure, which caused him to deviate from normal procedures. No injuries or damage to the aircraft or equipment occurred during this event. The weather was cold and overcast, and Air Methods is the vendor.

January 29, 2009

A Boston Medflight (Bedford, MA) aircraft was preparing to land at a referring hospital when the PIC noted the right main landing gear was not fully extended in the locked position, according to the indicator light. Boston MedFlight Operations center was notified that the AS365N2 Dauphin was returning to base airport with noted mechanical issue. During transit back to base, the PIC attempted to deploy gear according to emergency procedure checklist with no response. Airport tower, operations, and emergency personnel were notified of situation. Aviation Site Manager (ASM) reviewed emergency procedures and options with PIC via radio. After consultation with Era Med maintenance staff and field operations/emergency personnel, it was decided that the aircraft would touch down on left main gear to dissipate static electricity. PIC would then hover the aircraft at approximately 5 feet, allowing the ASM to attempt to manually deploy

right main gear by pulling on the wheel to assist deploying the gear. This was safely and successfully accomplished, and the aircraft landed safely with all three gears deployed and in locked position. The weather was clear and not a factor; Era Med is the vendor.

All Boston MedFlight operation, administrative, and Massport operations staff were debriefed. Era Med maintenance and American Eurocopter technical representatives are working to identify and resolve cause of gear malfunction.

February 5, 2009

While a Lifemed Alaska, LLC (Anchorage, AK) crew was taxiing from home base ramp in inclement weather, the Lear 35 ingested red construction barrier tape into both engines. The tape was unsecured on the roof of a hanger under construction across the ramp from our hangar. The tape had unspooled in the wind and was streaming across their ramp, over a chain link fence, and across our ramp. The PIC noticed the tape just as it was hitting the nose of the fuselage. He immediately shutdown both engines, and the aircraft was towed back to base. Another aircraft was dispatched and completed the transport without further incident. The weather was visibility 1/2 mile, wind gusting to 22 kts, snowing, night conditions.

After inspection the number one engine was found not to be damaged, and the number two engine was replaced. The aircraft was returned to service in a week. Aero Air, LLC is the vendor.

February 21, 2009

Upon liftoff and initial climb from Peoria International Airport (PIA), the OSF Saint Francis Medical Center Life Flight (Peoria, IL) flight nurse in the Bell 230 cabin heard a clunk. The pilot noted the #1 hydraulic system caution light illuminated with an accompanying drop in the #1 hydraulic press to 0 psi. The flight nurse in the co-pilot seat retrieved the aircraft emergency checklist, and procedures for a hydraulic system failure were implemented by the pilot as the flight nurse verbalized the steps. The crew returned to PIA and pilot executed a run-on landing. The aircraft was taken out of service and the crew debriefed. The weather was clear and not a factor.

Upon inspection, the maintenance department noted that the hydraulic line had a pinhole chaffed in it, leading to the loss of hydraulic fluid. This was repaired. The following morning, a test flight was performed and the

aircraft was placed back into service. OSF Aviation, LLC is the vendor.

February 22, 2009

While a STARS (Calgary, Alberta) team was preparing to leave the receiving hospital after a patient transport (with the rotors turning and all crewmembers secured inside the aircraft in preparation for departure), a man intentionally crashed his car through the perimeter security fence and came to a stop in very close proximity to the BK 117. As the driver exited the car and attempted to rush the helicopter, the non-flying pilot exited the aircraft and intercepted and restrained him from making contact with the aircraft and other crewmembers. No injuries and no aircraft damage resulted from this incident. The driver was subsequently arrested and is facing multiple serious charges.

February 23, 2009

While transporting a patient to a St. Louis area tertiary care center, the ARCH Air Medical Service (St. Louis, MO) pilot and medical crew heard a loud sound, followed by the complete loss of power on the BK-117's number two engine. The pilot secured the engine and immediately diverted to St. Louis Downtown Parks Airport, where a successful single engine run-on landing was performed. The patient and crew were then transported via ground ambulance to the receiving facility. The weather was clear and not a factor; Air Methods is the vendor.

The following day, the number two engine was replaced and the aircraft was returned to service. The engine was sent to the manufacturer for further inspection to determine the cause of the failure.

February 26, 2009

While an AirMed (Salt Lake City, UT) aircraft was landing at the University of Utah hospital helipad at 14:03, a large piece of black plastic sheeting, approx. 10-15 feet long by 2-3 feet wide, was drawn up toward the Bell 430 by its rotor wash and the prevailing winds around the pad. The pad is situated on the roof of a five level parking garage adjacent to the main hospital. There is an expansion project near the pad. The plastic reached the level of the helicopter on short final and was separated laterally by approximately 50 feet. It originated from the fenced-in construction storage area in the middle of the parking lot just below the approach path.

The appropriate construction managers were immediately contacted and the hazard was removed. Hospital safety department and AirMed's safety committee were notified and investigated the incident. The weather was clear and not a factor; Air Methods is the vendor.

March 2, 2009

During ground transport of a patient who was flown by Boston Medflight's (Bedford, MA) fixed aircraft, the contracted

private ambulance was struck on the passenger side by a private vehicle while traveling through a metropolitan city intersection. The Ford E-350, AEV Type II ambulance had come to a complete stop with lights and siren activated before proceeding through intersection. Local EMS/PD and FD responded. The EMT driver suffered minor injuries and was treated and released from local hospital. Patient and other EMT/CCT staff members sustained no injuries. This incident was reviewed/debriefed with contracted ambulance provider and Boston Medflight staff. The weather was clear and not a factor.

March 5, 2009

Life Flight III, part of Duke Life Flight (Durham, NC), was en route to airport for fuel when the EC-135 pilot reported multiple bird strikes to rotor system. The pilot landed safely at 0259 at the airport, and a mechanic was called to inspect the damage. The aircraft was immediately taken out of service for inspection. The weather was clear and not a factor; Air Methods is the vendor.

March 10, 2009

At 1528 a Stanford Life Flight (Stanford, CA) aircraft had a bird strike. The EC145 pilot observed a sparrow-sized bird, followed by sound of bird strike on the nose of the aircraft. No other symptoms of bird strike followed. The pilot diverted to nearest suitable landing area to confirm bird strike and to ascertain if the aircraft had sustained any damage. After landing, the aircraft was inspected by both the pilot and flight nurse. No evidence of a bird strike was discovered. Mission was continued to destination hospital.

Upon closer inspection a smear was discovered on the center support between the two front windscreens. Above the smear the remains of a finch-sized bird were found in the wiper blade. The rest of the aircraft was closely inspected again and no damage or remains were found, except one feather on the upper fuselage. The crew was debriefed, and then the program was returned to service. Air Methods is the vendor.

March 17, 2009

An Air Evac EMS, Inc. (West Plains, MO) Bell 206 L1 was landing for refuel at our base in Springfield, IL. The refueling pad is large enough to safely accommodate multiple aircraft. After completion of the approach to landing, the pilot hover taxied close to the fuel tank, and as he neared touchdown, the main rotor blade made slight contact with a parked and tied down aircraft blade. The pilot then hovered up and away from the parked aircraft and landed without further incident. No injuries were incurred and damage was limited to a small chip out of the tip cap of one of the main rotor blades. The FAA and NTSB were notified and an onsite review of the incident was completed. The weather was clear and not a factor; the program is its own vendor.

March 17, 2009

At 1535 JeffSTAT 1, part of JeffSTAT (Philadelphia, PA) departed from its base along the Delaware River at Sterling Aviation for an interfacility transport when the crew saw a large seagull approaching the EC135. Before they could alert the pilot, the bird flew into the main rotors. The pilot was able to maintain full control of the aircraft and returned to the helipad without incident. The aircraft was taken out of service and the mechanic called in. The bird was located on the adjacent deck area of the helipad. Multiple feathers and blood spatters were identified on the aircraft and, once removed, revealed no damage. The aircraft was cleared and returned to service 2 hours later. The weather was clear and not a factor; Air Methods is the vendor.

March 21, 2009

A STARS (Calgary, Alberta) team was en route to a scene location to rendezvous with a ground ambulance. Approximately 5 minutes before ETA, a landing zone brief was requested with the responding fire department. The initial LZ brief was lacking in detail; consequently, AMC (air medical crew) prompted the briefer for additional information, including hazards, blowing snow and loose impediments, possible wire hazards, and wind direction. According to the briefer, the wind was calm; there were no hazards and no wires.

The BK 117 approached from the east with an orbit of the LZ to verify the briefing. The AMC were on "hot mike" and were oriented to the LZ to assist with the recce and note any hazards. The entire crew was talked through the downwind and approach.

A steeper-than-normal approach was flown due to the high light standards and fencing on the approach path. The approach was also flown somewhat slower than normal as a precaution, with the fixed landing light and MASSEY lights on.

On final approach, the captain caught sight of wires directly in the approach path and immediately applied collective and cyclic to avoid the hazard. The avoidance maneuver was successful, and the mission was completed without further incident. Witnesses estimated that the aircraft missed the wires by approximately 1 foot.

There were two strands of high tension wires on the approach, which were not briefed by the LZ officer nor seen during the recce orbit. The approach angle was such that the wires and the poles were somewhat obscured by the lights surrounding the compound and the lights from the emergency vehicles at the LZ.

March 24, 2009

A Lifeguard Air Emergency Services (Albuquerque, NM) crew was en route to destination airport; upon approach, the BE-90L pilot selected gear down and the left main gear light did not illuminate. The indicator bulb tested good. The pilot did not note any abnormal sounds during the gear extension. In addition, the red gear handle light went

out during the extension process and the gear warning horn did not come on with power reduction or extension of flaps beyond the approach position.

The flight was aborted and aircraft returned to home base (airport of origin). Appropriate emergency procedures were followed, including the initiation of PAIP. ATC advised of emergency and priority was given to aircraft. Emergency procedures reviewed with crew, and one medical crewmember moved to the copilot seat and the other to a shoulder-belted aft seat. Pilot requested a low pass over the tower, and tower advised gear appeared to be in its normal position. The pilot then executed a landing on right main first, bled off speed, and touched down left gear without incident. The weather was clear and not a factor; Seven Bar Flying Service is the vendor.

The maintenance staff found broken downlock switch wires in the wheel well. Wires were repaired and aircraft was returned to service that same evening.

March 27, 2009

Life Flight II, Geisinger Life Flight's (Danville, PA) aircraft based in St College, responded to Bucktail Medical Center in Renovo, PA, for an interfacility transport. With the patient and med crew on board in Renovo, the EC145 pilot attempted to start engine #1. A change in the voltage was noted with no spooling up of the engine. The start was aborted. After a careful review of the checklist, the pilot attempted to start engine again. With this attempt a heavy smoke condition was noted outside the aircraft. The start was aborted, and the crew immediately exited the aircraft, emergently egressing the patient. After all occupants were out of the aircraft, the pilot, with a fire extinguisher in hand, opened the engine cowling and saw that the smoke was coming from the starter/generator, which was subsiding.

The patient was transported by another Life Flight aircraft and maintenance was dispatched. It was determined the starter/generator failed and was replaced. The aircraft returned to service later the same day. The weather was clear and not a factor; Era Med is the vendor.

March 28, 2009

During cruise flight while returning from a referring hospital, an AirMed (Salt Lake City, UT) Bell 430 was struck by a seagull. The crew heard and felt a thump under their feet. After evaluating the incident and given their proximity to the receiving hospital, they elected to land at the hospital. The aircraft was inspected by maintenance and placed back into service after no damage was found. The weather was clear and not a factor; Air Methods is the vendor.

March 29, 2009

An Air Evac EMS, Inc. (West Plains, MO) crew was completing an uneventful flight returning to base after

refueling. The Bell 206L3 pilot performed a postflight inspection and found a large crack in one of the main rotor blades, running from the trailing edge of the blade directly toward the rear of the spar. It then made a T and proceeded approximately 6" inboard and outboard. The crack went completely through the blade, but the spar was not compromised. No other signs of damage were noted. The aircraft was immediately grounded and released to maintenance. The NTSB and FAA are working with company officials and Bell Helicopters as we proceed to determine the root cause of this occurrence. The weather was clear and not a factor; the program is its own vendor.

April 4, 2009

En route from a referral hospital in Wynne, AR, to Arkansas Children's Hospital with a patient on board, Angel One Transport (Little Rock, AR) was engaged by a bright green laser that tracked the S-76 C aircraft for three miles. The aircraft was initially engaged at position N 35 49 85 W 091 30 33 at an altitude of 3000ft MSL heading 245 degrees. The laser emanated from a point east of town (Des Arc) on what appeared to be Highway 323 within a quarter mile radius of the N 34 58 62 W 091 29 70. Angel One dispatch was immediately notified of GPS location, and the local sheriff department was notified. The weather was clear and not a factor; the program is its own vendor.

Appropriate documentation and reporting was complete with FAA Operations Control Center in Washington, DC. At this time, the sheriff department has not found a source for the laser and the incident is considered open.

April 8, 2009

An Air Evac EMS, Inc. (West Plains, MO) Bell 206 L3 responded to provide an interfacility transport in central Texas. The last leg of the flight departed with a patient on board at 00:35 Central. The flight proceeded uneventfully until 01:00, at which time the pilot reported a possible bird strike and made a precautionary landing in a small field. Prior to landing, the pilot reported hearing and feeling a loud prolonged "thud" during cruise flight at 1000' AGL and 110 kts. The airframe "wallowed" laterally and he felt resistance in the flight control (cyclic), followed by all control returning to normal. His postflight inspection revealed the left-hand vertical winglet on the horizontal stabilizer was missing. It apparently had impacted the lower vertical fin, causing minor damage to the leading edge up to the honeycomb. None of the crew or passengers sustained any injuries. The patient was transferred on to receiving facility by ground ambulance. The aircraft was grounded and released to maintenance, and the NTSB and FAA were notified. The weather was clear and not a factor; the program is its own vendor.