

QUANTITATIVE INQUIRY INTO
FEDERAL AVIATION ADMINISTRATION
FLIGHT INSPECTION SERVICES
SAFETY SIGNIFICANT EVENTS

By

Bradley V. Keith

Bachelor of Science
Oklahoma State University
Stillwater, Oklahoma
2006

Masters of Science; Aviation and Space
Oklahoma State University
Stillwater, Oklahoma
2009

Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
DOCTOR OF EDUCATION
December, 2014

QUANTITATIVE INQUIRY INTO
FEDERAL AVIATION ADMINISTRATION
FLIGHT INSPECTION SERVICES
SAFETY SIGNIFICANT EVENTS

Dissertation Approved:

Dr. Steve Marks

Dissertation Adviser and Chair

Dr. Fred Hansen

Committee Member

Dr. Chad Depperschmidt

Committee Member

Dr. James Key

Outside Committee Member

ACKNOWLEDGEMENTS

The completion of this dissertation would not have been possible without the help of numerous people along the way. First and foremost I wish to thank my wife Emily for her kind heart, support, and encouragement; I wouldn't want anyone else by my side. To my young sons Jacob and Jon, you won't remember this part of my journey but I never want you to forget that you are strong enough to finish whatever you start. It always seems impossible until it is done. I hope you instill the importance of education, hard work and perseverance in your own children like your grandparents and great grandparents did for me.

I also would like to thank the numerous academic professionals I've worked with to reach this goal. Dr. Mary Kutz, thank you for being my advisor from undergrad through graduate college, you have always inspired me to go further. To the members of my dissertation committee Dr. Steve Marks, Dr. Chad Depperschmidt, Dr. Fred Hansen, and Dr. James Key; thank you for your time, knowledge, and instruction to make me a better researcher and for inspiring future generations to never stop learning

Acknowledgements reflect the views of the author and are not endorsed by committee members or Oklahoma State University.

Name: BRADLEY V. KEITH

Date of Degree: DECEMBER, 2014

Title of Study: QUANTITATIVE INQUIRY INTO FEDERAL AVIATION
ADMINSTRATION FLIGHT INSPECTION SERVICES SAFETY
SIGNIFICANT EVENTS

Major Field: APPLIED EDUCATIONAL STUDIES, AVIATION & SPACE

Abstract: The purpose of this case study of the FAA, Flight Inspection Services Safety Significant Events database from 2009 through 2012 was to discover if there are relationships between a set of independent variables and the dependent variable of a reportable event. These independent variables were categorized by Year, Month, Day, Hour, Phase of Flight, Aircraft System, and Fleet Type in which they occurred. This will help determine safety trends of events that occur in flight or on the ground that affect, or could affect, the safety of an FAA aircraft or aircrew member. The study should not only benefit the organization by providing a categorical perspective from which future decisions may be enriched, but should also serve as an educational resource to other CFR Part 135 Operators.

TABLE OF CONTENTS

Chapter	Page
I. INTRODUCTION	1
Safety Management System.....	2
Safety Reporting System.....	3
Problem Statement	5
Purpose of the Study	6
Research Hypotheses	6
Significance of the Study	8
Assumptions.....	8
Scope and Limitations of the Study	9
Definitions of Terms	9
II. REVIEW OF LITERATURE.....	13
Quantitative Inquiry Literature Review	14
Aviation Incident	14
Individual and Organizational Accidents.....	17
Current Initiatives to improve Aviation Safety.....	21
Potential Improvements	26
III. METHODOLOGY	31
Research Questions.....	32
Research Hypotheses	33
Research Design.....	34
Sample Selection.....	35
Reliability.....	35
Validity	36
Data Gathering Procedures	37
Institutional Review Board Compliance.....	38
Data Types	38
Data Removal.....	39
Statistical Tools.....	39
Statistical Procedures	39

Chi-Square Procedures.....	40
Chapter	Page
IV. FINDINGS.....	42
Hypothesis 1 Testing Year.....	43
Hypothesis 2 Testing Month.....	46
Hypothesis 3 Testing Day.....	50
Hypothesis 4 Testing Local Time.....	53
Hypothesis 5 Testing Aircraft Type.....	59
Hypothesis 6 Testing Phase of Flight.....	62
Hypothesis 7 Testing Aircraft System.....	66
V. CONCLUSIONS AND RECOMMENDATIONS.....	71
Summary.....	71
Conclusions.....	72
Hypothesis 1 Conclusion.....	73
Hypothesis 2 Conclusion.....	74
Hypothesis 3 Conclusion.....	75
Hypothesis 4 Conclusion.....	76
Hypothesis 5 Conclusion.....	77
Hypothesis 6 Conclusion.....	78
Hypothesis 7 Conclusion.....	79
Aviation Stakeholder Recommendations.....	80
Recommendations for Additional Research.....	81
REFERENCES.....	86
APPENDICES.....	89
APPENDIX A – IRB APPROVAL FORM.....	90
APPENDIX B – FREEDOM OF INFORMATION REQUEST.....	94
APPENDIX C – FREEDOM OF INFORMATION ACCEPTANCE.....	97
APPENDIX D – FAA FIS SSE DATASET.....	99
APPENDIX E – RESEARCHER CURRICULIM VITAE.....	333

LIST OF TABLES

Table	Page
1. SPSS Reporting by Year	44
2. SPSS Reporting by Year Descriptive	44
3. SPSS Reporting by Year Expected	44
4. SPSS Reporting by Year Test Statics	45
5. SPSS Reporting by Year Frequency	45
6. SPSS Reporting by Month.....	47
7. SPSS Reporting by Month Descriptive	47
8. SPSS Reporting by Month Expected.....	48
9. SPSS Reporting by Month Test Statics	49
10. SPSS Reporting by Month Frequency	49
11. SPSS Reporting by Day.....	51
12. SPSS Reporting by Day Descriptive	51
13. SPSS Reporting by Day Expected.....	52
14. SPSS Reporting by Day Test Statics	52
15. SPSS Reporting by Day Frequency.....	53
16. SPSS Reporting by Local Time	55
17. SPSS Reporting by Local Time Descriptive.....	56

18. SPSS Reporting by Local Expected.....	57
19. SPSS Reporting by Local Time Test Statics	58
20. SPSS Reporting by Local Time Frequency	59
21. SPSS Reporting by Aircraft Type.....	60
22. SPSS Reporting by Aircraft Type Descriptive	61
23. SPSS Reporting by Aircraft Type Expected.....	61
24. SPSS Reporting by Aircraft Type Test Statics	61
25. SPSS Reporting by Aircraft Type Frequency.....	62
26. SPSS Reporting by Phase of Flight	64
27. SPSS Reporting by Phase of Flight Descriptive.....	64
28. SPSS Reporting by Phase of Flight Expected	65
29. SPSS Reporting by Phase of Flight Test Statics	65
30. SPSS Reporting by Phase of Flight Frequency	30
31. SPSS Reporting by Aircraft System	68
32. SPSS Reporting by Aircraft System Descriptive	68
33. SPSS Reporting by Aircraft System Expected	69
34. SPSS Reporting by Aircraft System Test Statics.....	69
35. SPSS Reporting by Aircraft System Frequency	70

LIST OF FIGURES

Figure	Page
1. James Reason Swiss Cheese Model	16
2. Hollinger Safety Risk Management Design	27
3. Hollinger Hazard Risk Mitigation	28

CHAPTER I

INTRODUCTION

During 2010, Code of Federal Regulations Part 135 operators flew over 3.12 million hours (GSA Survey, 2010). These organizations are comprised of public and private entities that operate under the commuter or on demand operations of each person who holds or is required to hold an Air Carrier operating Certificate under part 119 (CFR, 2013). FAR Part 135 applies to turbojet engine powered aircraft with 1-30 seats, non-transport category turbo-propeller powered aircraft with 10-19 seats, and transport category turbo props with 20-30 seats (Grundig, 2013). Some of the services these operators provide are air taxi, tours, medical and others that can range from small private companies to large federal agencies who operate under a more a stringent set of federal regulations because of their business or mission needs. The Federal Aviation Administration's Flight Inspection Services is one of the organizations that holds a CFR Part 135 Certificate due to the complexity and inherent danger of its missions, which require a higher level of safety. Flight Inspection Services provides airborne flight inspection of electronic signals-in-space from ground-based navigational aids that

support aircraft departure, en route, and arrival flight procedures in the National Airspace System (“Flight inspection services”, 2014). Flight procedures are evaluated for accuracy, aeronautical data, human factors, fly ability, and obstacle clearance ("Flight inspection services," 2014). The organization accomplishes its mission by its ability to operate 24 hours a day and 7 days a week; for an average of 15,000 through 20,000 flight hours per year with a fleet of 32 specially-equipped flight inspection aircraft.

Safety Management System

Safety Management Systems (SMSs) integrate modern safety risk management and safety assurance concepts into repeatable, proactive systems. SMSs emphasize safety management as a fundamental business process to be considered in the same manner as other aspects of business management ("Safety management system," 2014). By recognizing the organization's role in accident prevention, SMSs provide to both certificate holders and the FAA:

- A structured means of safety risk management decision making
- A means of demonstrating safety management capability before system failures occur
- Increased confidence in risk controls through structured safety assurance processes

- An effective interface for knowledge sharing between regulator and certificate holder
- A safety promotion framework to support a sound safety culture

("Safety management system," 2014)

This study focused on the safety reporting aspect of SMS through the non-punitive knowledge sharing between regulator and certificate holders through the organizations Safety Reporting System, Safety Significant Event reports.

Safety Reporting System

As part of the Flight Inspection Flight Safety Program, the Safety Reporting System (SRS) was developed for Crewmembers and Dispatchers to report safety and operational concerns. These reports are used to help identify areas of risk to our flight operations in a proactive manner and implement corrective actions in order to reduce the potential of an incident or accident ("Flight inspection services," 2014). There are three types of reports that can be submitted through Flight Inspections safety reporting system. Aviation Safety Action Program (ASAP) which is a Crewmember's or Dispatcher's action or inaction causes or contributes to an unsafe condition. Safety Significant Events (SSE) which is an event that occurs in flight or on the ground which affects or could affect the safety of an FAA aircraft or aircrew member. Safety Improvement Report (SIR) which is a condition, situation, procedure, behavior, or policy is identified as a real or potential hazard affecting the flight inspection program ("Flight inspection services," 2014). Voluntary reporting programs are

utilized between aircraft operators and the FAA to enhance flight safety. The goal of safety reporting is to detect problems and negative trends in flight operations before those problems cause an accident. Employees are encouraged to submit voluntary reports without fear of being reprimanded by their employer, and without fear of being legally implicated by the FAA. Reports remain anonymous and can be paired with data from flight recorders to analyze the entire scope of the situation. It is intended to create a nonthreatening environment that encourage the employee to voluntarily report safety issues even though they may involve violation of Title 49 of the United States Code (49 U.S.C.), Subtitle VII, or violation of Title 14 of the Code of Federal Regulations 14 CFR ("Aviation safety action," 2013).

The safety partnership between the Federal Aviation Administration (FAA) and the certificate holder and may include any third party such as an employee labor organization. These programs are intended to generate safety information that may not otherwise be obtainable (ASAP, 2013). The Federal Aviation Administration has determined that identifying these precursors is essential to further reducing the already low accident rate. Under voluntary reporting systems, safety issues are resolved through corrective action rather than through punishment or discipline. The reporting provides for the collection, analysis, and retention of the safety data that is obtained. Voluntarily reported safety data, which would otherwise be unobtainable, is then used to develop corrective actions for identified safety concerns, and to educate the appropriate parties to prevent a reoccurrence of the same type of safety event. These programs are designed to encourage participation from various employee

groups, such as flight crewmembers, mechanics, flight attendants, and dispatchers ("Aviation safety action," 2013).

This study presents a case study of the Safety Significant Events (SSE) over the 2009 through 2012 period of time for the Federal Aviation Administration, Flight Inspection Services Organization. A Safety Significant Event is an event that occurs in flight or on the ground, other than an aircraft accident or incident as defined in 49 CFR Part 830, which affects or could affect the safety of an FAA aircraft or aircrew member. In addition any use of the abnormal or emergency checklist requires an SSE Report ("Flight inspection services," 2014). These reports collect valuable information that can provide the organization with a powerful tool for making informed safety decisions. Flight Inspection Services is headquartered in Oklahoma City, Oklahoma, with Field offices housed in Atlanta, Georgia; Battle Creek, Michigan; Atlantic City, New Jersey; Sacramento, California; and Anchorage, Alaska. The purpose of this study was to objectively examine the Safety Significant Events that occurred, and to quantitatively review those findings to understand safety trends.

Problem Statement

During a 4 year time period Flight Inspection Services recorded 185 safety events that the organization classified as having an impact to FAA aircraft or aircrew member. To date no formal quantitative study had been conducted of the categorical events to benefit the

safety of the organization or made public for other Part 135 operators to read and draw their own conclusions

Purpose of the Study

The purpose of this case study of the FAA, Flight Inspection Services Safety Significant Events database from 2009 through 2012 was to discover if there are relationships between a set of independent variables and the dependent variable of a reportable event. This will help determine safety trends of events that occur in flight or on the ground that affect, or could affect, the safety of an FAA aircraft or aircrew member. The study should not only benefit the organization by providing a categorical perspective from which future decisions may be enriched, but should also serve as an educational resource to other CFR Part 135 Operators.

Research Hypotheses

The research addressed the following questions:

1. Null Hypothesis (H_0): There will be no significant relationship between the specific year and increased probability for an accident or incident.

Alternative Hypothesis (H_{a1}): There will be a significant relationship between the specific year and increased probability for an accident or incident.

2. Null Hypothesis (H_{o2}): There will be no significant relationship between the specific month and increased probability for an accident or incident.

Alternative Hypothesis (H_{a2}): There will be a significant relationship between the specific month and increased probability for an accident or incident.

3. Null Hypothesis (H_{o3}): There will be no significant relationship between the specific day and increased probability for an accident or incident.

Alternative Hypothesis (H_{a3}): There will be a significant relationship between the specific day and increased probability for an accident or incident.

4. Null Hypothesis (H_{o4}): There will be no significant relationship between the specific hour and increased probability for an accident or incident.

Alternative Hypothesis (H_{a4}): There will be a significant relationship between the specific hour and increased probability for an accident or incident.

5. Null Hypothesis (H_{o5}): There will be no significant relationship between a specific aircraft type and frequency of failures that lead to an accident or incident.

Alternative Hypothesis (H_{a5}): There will be a significant relationship between a specific aircraft type and frequency of failures that lead to an accident or incident.

6. Null Hypothesis (H_{o6}): There will be no significant relationship between a specific phase of flight and frequency of failures that lead to an accident or incident.

Alternative Hypothesis (H_{a6}): There will be a significant relationship between a specific phase of flight and frequency of failures that lead to an accident or incident.

7. Null Hypothesis (H_{o7}): There will be no significant relationship between a specific aircraft system and frequency of failures that lead to an accident or incident.

Alternative Hypothesis (H_{a7}): There will be a significant relationship between a specific aircraft system and frequency of failures that lead to an accident or incident.

Significance of the Study

This research study is significant because it will focus on how Part 135 Operators can address the critical events that impact flight safety. The independent variables that were selected for this study are imperative to help further understand when the failures were actually occurring and what systems failed. The research will provide a detailed analysis of those variables to assist with the possible development of future training and risk mitigations to improve flight safety.

Assumptions

The following assumption was made during the course of the study:

The reported information contained within the Safety Significant Reports was historical, crew member self-reported, and assumed to be an accurate and honest record of the safety event.

Scope and Limitations of the Study

The scope of this study is limited only to the quantitative research of the Flight Inspection Services Safety Significant Events database during the 2009 through 2012 time period. The database does not contain outside organizations' safety events, and conclusions are drawn only from the organizations' data that was provided as a result of a 2013 Freedom of Information Request to the Federal Aviation Administration, Flight Inspection Services.

Definitions of Terms

Aircrew: The crew manning an airplane.

Safety: Safety is the state of being "safe" the condition of being protected against physical, social, spiritual, financial, political, emotional, occupational, psychological, educational or other types or consequences of failure, damage, error, accidents, harm or any other event which could be considered non-desirable. Safety can also be defined to be the control of recognized hazards to achieve an acceptable level of risk.

Federal Aviation Administration: The Federal Aviation Administration (FAA) is the national aviation authority of the United States of America. An agency of the United States Department of Transportation, it has authority to regulate and oversee all aspects of civil aviation in the United States. The Federal Aviation Act of 1958 created the organization under the name "Federal Aviation Agency", and adopted its current name in 1966 when it became a part of the United States Department of Transportation.

Department of Transportation: The Department of Transportation (DOT) is the most common name for a government agency in North America devoted to transportation. The largest is the United States Department of Transportation, which oversees interstate travel. All U.S. states, Canadian provinces, and many local agencies also have similar organizations and provide enforcement through DOT officers.

Nav aids: A navigational aid is any sort of marker which aids the traveler in navigation; the term is most commonly used to refer to nautical or aviation travel. Common types of such aids include lighthouses, buoys, fog signals, and day beacons.

Federal Aviation Regulations: The Federal Aviation Regulations, or FARs, are rules prescribed by the Federal Aviation Administration governing all aviation activities in the United States. The FARs are part of Title 14 of the Code of Federal Regulations. A wide variety of activities are regulated, such as airplane design, typical airline flights, pilot training activities, hot-air ballooning, lighter-than-air aircraft, man-made structure heights,

obstruction lighting and marking, and even model rocket launches and model aircraft operation. The rules are designed to promote safe aviation, protecting pilots, flight attendants, passengers and the general public from unnecessary risk.

Part 135: Operating Requirements: Commuter and On Demand Operations and Rules Governing Persons on Board Such Aircraft.

Flight Inspection: The evaluation process, using properly equipped aircraft, regarding continuity, integrity and accuracy of significant parameters from radio navigation aids and procedures, aiming their calibration with international standards.

Flight Inspection Systems: Flight Inspection Systems are installed in aircraft, and they have dedicated antennas, receivers/transceivers and sensors to collect data from navigation aids under inspection. The data received by this equipment are decoded by flight inspection computers and compared with the real aircraft position, which accuracy is essential. The position can be calculated by several devices and techniques or sent to the flight inspection aircraft by external devices. The process results are displayed on operator/inspector workstations, also installed in the aircraft.

Freedom of Information Act: Freedom of Information Act (FOIA) provides that any person has a right, enforceable in court, to obtain access to federal agency records, except to the extent that such records (or portions of them) are protected from public disclosure by one of

nine exemptions or by one of three special law enforcement record exclusions. A FOIA request can be made for any agency record.

Flight Operations Quality Assurance: FOQA is a voluntary safety program designed to improve aviation safety through the proactive use of flight recorded data. Operators will use these data to identify and correct deficiencies in all areas of flight operations. Properly used, FOQA data can reduce or eliminate safety risks, as well as minimize deviations from regulations.

Safety Significant Event: A Safety Significant Event (SSE) is an event that occurs in flight or on the ground, other than an aircraft accident or incident as defined in 49 CFR Part 830, which affects or could affect the safety of an FAA aircraft or aircrew member. In addition, any use of the abnormal or emergency checklist requires an SSE report.

Safety Management System: SMS is the formal, top-down business-like approach to managing safety risk, which includes a systemic approach to managing safety, including the necessary organizational structures, accountabilities, policies and procedures.

CHAPTER II

REVIEW OF LITERATURE

The purpose of this case study of the FAA, Flight Inspection Services Safety Significant Events database from 2009 through 2012 was to discover if there are relationships between a set of independent variables and the dependent variable of a reportable event. These independent variables were categorized by Year, Month, Day, Hour, Phase of Flight, Aircraft System, and Fleet Type in which they occurred. This will help determine safety trends of events that occur in flight or on the ground that affect, or could affect, the safety of an FAA aircraft or aircrew member. The study should not only benefit the organization by providing a categorical perspective from which future decisions may be enriched, but should also serve as an educational resource to other CFR Part 135 Operators.

The aviation industry has been under constant change since its inception in 1903. Each decade leaps and bounds of technological and engineering advancements have been made. As the aviation industry becomes more complex, so do the problems that face it and data must be collected, analyzed, and reviewed to implement the proper mitigations to address those challenges..

Quantitative Inquiry Literature Review

To comply with the requirements of quantitative research, the review of literature for this study is limited to industry and academic sources. All information that was reviewed is from the cited writer's perspective and no inferences or assumptions were made about their conclusions. All the data that was reviewed has been relayed to be fact and no inferences or assumptions were made. By definition, measurement must be objective, quantitative and statistically valid (Imperial COE, 2006). This review examined the literature pertaining to: 1) aviation incidents or a combination of incidents that could lead to an accident; 2) initiatives to improve aviation safety; and 3) potential improvements that can be made to further improve aviation safety.

Aviation Incident

There is a line between what is classified as an aviation incident verses what is known as an aviation accident as specified by 49 CFR Part 830. This study focuses on examining several areas of categorical data contained within the hundreds of Safety Significant Event incident reports that Flight Inspection Services experienced over a 4 year time period. For the hundreds of incidents that an organization could experience within each year, to date none of them are directly linked to creation of a major accident. But each of these incidents in succession can create an environment that could allow a larger accident to happen. The theoretical model for this research is Reasons Swiss Cheese model which will be explained later in this chapter by Figure 1

Most pilots and aviation workers are aware that all accidents have to be reported to the National Transportation Safety Board (NTSB) but are unaware that certain incidents are also reportable.

To figure out whether or not a situation qualifies as an “aircraft accident” we must look to the definitions in Part 830. The NTSB defines an “aircraft accident” to mean “an occurrence associated with the operation of an aircraft which takes place between the time any person boards the aircraft with the intention of flight and all such persons have disembarked, and in which any person suffers death or serious injury, or in which the aircraft receives substantial damage.” The initial threshold for classification as an aircraft accident is that the aircraft is being operated “with the intention of flight.” Incidents which occur while the aircraft is operated for the sole purpose of moving it around the ramp, moving it from its hangar to the maintenance hangar, or other ground only operations fall outside of the definition of aircraft accident, regardless of the extent of damage or personal injury. However, be careful here. Incidents which occur during taxi preceding or following a flight may qualify as aircraft accidents. That extra taxi time between the normal ramp space and the maintenance hangar after the passengers have disembarked may still be part of an operation relating to flight if any of the crew members remain on board (Edwards, 2009, p. 9).

If an error is made in the reporting process and there was a misclassification of an incident as an accident, it could affect Federal Aviation Administration (FAA) sanction

protection typically provided under many voluntary disclosure programs (Edwards, 2009). The conditions necessary for an organizational accident is the rate conjunction of a set of holes in successive defenses, allowing hazards to come into damaging contact with people and assets. These ‘windows of opportunity’ are rare because of the multiplicity of defenses and the mobility of the holes (Reason, 1997).

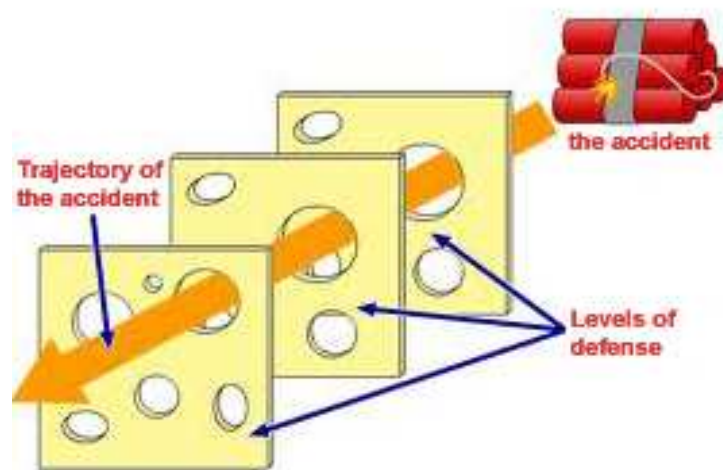


Figure 1. James Reason Swiss Cheese Model

Active failures create gaps in the defenses in at least two ways. First the front line personnel may deliberately disable certain defenses in order to achieve local operation objectives (Reason, 1997). Second, front line operators may unwittingly fail in their role as one of the systems most important lines of defense. A common example would be the wrong diagnosis of an off-normal system state, leading to an inappropriate course of recovery actions. Since no one can foresee all the possible scenarios of disaster, it is therefore inevitable that some defensive weaknesses will be present from the very beginnings of a systems productive life, or will develop unnoticed or at least uncorrected

during its subsequent operations (Reason, 1997). Aviation Incidents are the reporting of a defensive weakness. Something abnormal happened with the aircraft and while its occurrence might not be immediately life threatening, it can serve as a warning of a larger more systemic problem.

Individual and Organizational Accidents

Accidents have numerous sources, involving many different people, who are operating at different levels of competency within an organization. Individual accidents are ones in which a specific person or group is often both the agent and victim of the accident. The consequences to the people concerned may be great, but their spread is limited. Organizational accidents, on the other hand, can have devastating effects on uninvolved populations, assets and the environment (Reason, 1997). An actual Aviation accident is defined in 49 CFR Part 830:

This notification process is required in the following circumstances:

(a) An aircraft accident or any of the following listed incidents occur:

(1) Flight control system malfunction or failure;

(2) Inability of any required flight crewmember to perform normal flight duties as a result of injury or illness;

- (3) Failure of structural components of a turbine engine excluding compressor and turbine blades and vanes;
- (4) In-flight fire; or
- (5) Aircraft collide in flight.
- (6) Damage to property, other than the aircraft, estimated to exceed \$25,000 for repair (including materials and labor) or fair market value in the event of total loss, whichever is less.
- (7) For large multi-engine aircraft (more than 12,500 pounds maximum takeoff weight);
 - (i) In-flight failure of electrical systems which requires the sustained use of an emergency bus powered by a backup source such as a battery, auxiliary power unit, or air driven generator to retain flight control or essential instruments;
 - (ii) In-flight failure of hydraulic systems that results in sustained reliance on the sole remaining hydraulic or mechanical system for movement of flight control surfaces;
 - (iii) Sustained loss of the power or thrust produced by two or more engines; and
 - (iv) An evacuation of an aircraft in which an emergency egress system is utilized.
- (b) An aircraft is overdue and is believed to have been involved in an accident ("Title 49 CFR 830," 2014).

Organization accidents are hard to recognize and control before they happen due to their complex natures. Typically, numerous latent conditions have to perfectly align for a mass failure to occur. Difficult though they may be to model, we have to struggle to find some way of understanding the development of organizational accident if we are to achieve any further gains in limiting their occurrence (Reason, 1997). Outside of the immediate loss of life and equipment, very few aviation companies can withstand the financial fallout of a major accident. High risk systems have a double penalty: because normal accidents stem from the mysterious interaction of failures, those closest to the system, the operators, have to be able to take independent and sometimes require creative action. But because these systems are so tightly coupled, control of the operators must be centralized because there is little time to check everything out and be aware of what another part of the system is doing (Perrow, 1999). Each accident has its own very individual pattern of cause and effect. Apart from the fact that they are all bad news, this level of description seems to defy generalization and implies that we clearly need to investigate more deeply into some common underlying structure and process to find the right level of explanation (Reason, 1997). Time and time again warnings are ignored, unnecessary risks taken, sloppy work done, deception and downright lying practiced (Perrow, 1999). When an organizational accident occurs, numerous barricades and protections have failed that led to the loss of an asset; whether it's a manufactured good, financial, or human life. In an ideal world, the level of protection should match the hazards of the productive operations. The more extensive the productive operations, the greater the hazard exposure and so also is the need for corresponding protection (Reason, 1997). If someone viewing the result of an accident or incident discovers unsafe acts

preceding a bad outcome, it would probably end the discovery phase. But within the last 20 years, more research has been done into identifying active failures that also occurred prior to a major accident (Reason, 1997). Today, neither investigators nor responsible organizations are likely to end their search for the cause of an organizational accident with the mere identification of ‘sharp end’ human failures. Such unsafe acts are now seen more as consequences than as principal failures (Reason, 1997). For example, virtually every system will examine places “operator error” high on the list of causal factors—generally about 60 to 80 percent of accidents are attributed to this factor. But if, as we shall see time and time again, the operator is confronted by unexpected and usually mysterious interactions among failures, saying that he or she should have zigged instead of zagged, is possible only after the fact (Perrow, 1999). Human reaction is often to blame a person rather than examining the latent conditions that were present to allow a failure. Latent conditions are to technological organization what resident pathogens are to the human body. Like pathogens, latent conditions—such as poor design, gaps in supervision, undetected manufacturing defects or maintenance failures, unworkable procedures, clumsy automation, shortfalls in training, less than adequate tools and equipment – may be present for many years before they combine with local circumstances and active failures to penetrate the systems many layers of defense (Reason, 1997). We have produced designs so complicated that we cannot anticipate all the possible interactions of the inevitable failures: we add safety devices that are deceived or avoided or defeated by hidden paths in the systems. The systems have become more complicated because either they are dealing with more deadly substances, or we demand they function in ever more hostile environments or with ever greater speed and volume

(Perrow, 1999). It is particularly important to evaluate technological fixes in the systems that we cannot, or will not, do without. Fixes, including safety devices, sometimes create new accidents, and quite often merely allow those in charge to run the system faster, or in worse weather, or with bigger explosives (Perrow, 1999). Latent conditions are present in all situations and are an ordinary part of life. However, the determination must be made about how great a risk they are and if their mitigation has a greater cost than their risk.

Current Initiatives to improve Aviation Safety

The United States Aviation industry continues to grow at a record pace. During 2013, a record 826 million domestic and international customers traveled using commercial air transportation (DOT, 2013). Because the number of flights has continued to grow, the aviation industry is constantly looking for ways to improve safety. To understand aircraft safety, an environment must be established to encourage voluntary reporting of users so others can learn from the mistakes and put the proper mitigations in place. An Aviation Safety Action Program (ASAP) is a reporting program that allows employees of participating air carriers and repair station certificate holders to identify and report safety issues to management and to the FAA for resolution, without fear that the FAA will use reports accepted under the program to take legal enforcement action against them, or that companies will use such information to take disciplinary action (Jackson, 2013). Airlines began using ASAP programs in the early 1990s. The “P” in ASAP was originally “Partnership” rather than “Program” because ASAPs were born as a

partnership between the FAA, a company and its labor unions. Reporting wasn't confined to the cockpit; it grew to encompass pilots, flight attendants, dispatchers and maintenance workers. In the airline environment, the ASAP is a key component of a Safety Management System (SMS) that also includes a Flight Operations Quality Assurance (FOQA) program and Internal Evaluation Program (IEP). One of the key roadblocks to making ASAPs available outside of the airline environment is the difficulty in duplicating the "ERC" found in airline ASAPs. An Event Review Committee (ERC) reviews and analyzes the reports submitted, identifies actual or potential safety problems from the information in the reports, and proposes solutions for those problems to the company (Jackson, 2013). The ACSF ASAP manager maintains a database that continually tracks each event and the analysis of those events. The ACSF participating company database is structured to share needed safety information and still maintain anonymity. The ERC conducts a 12-month review of the participating company's ASAP database with emphasis on determining whether corrective actions have been effective in preventing or reducing the recurrence of safety-related events of a similar nature. That review includes recommendations for corrective action for recurring events indicative of adverse safety trends (Jackson, 2013). The overall growth and development of SMS in the United States has been slower than other areas of the world, principally outside of Part 121 operations. Employees fear that a company may use the system as a punishment tool. Managers fear what lawyers might do with the system data after an accident. Employees and managers alike fear what the FAA might do with the reports in an enforcement case (Jackson, 2013). Commercial air carrier and general aviation representatives, working with the FAA on parallel initiatives to significantly reduce the number of aviation accidents,

believe their efforts already are bearing fruit and will ultimately permit them to achieve some aggressive safety goals (B.A. 2001). Companies that properly disclose a violation under the voluntary program receive a letter of correction in lieu of civil penalty action. Once the FAA issues a letter of correction, the agency considers the case closed unless the company fails to follow through with the "comprehensive fix" developed by the company to avoid future violations (Jackson, 2007). In evaluating whether a violation is covered by the program the FAA must ensure that five conditions are met. First, The company has notified the FAA of the apparent violation immediately after detecting it and before the FAA has learned of it by other means. Second, the apparent violation was inadvertent. Third, the apparent violation does not indicate a lack, or reasonable question, of qualification of the company. Fourth, immediate, satisfactory action was taken upon discovery to terminate the conduct that resulted in the apparent violation. Fifth, the company has developed or is developing a comprehensive fix and schedule of implementation satisfactory to the FAA. The comprehensive fix includes a follow-up self-audit to ensure that the action taken corrects the noncompliance (Jackson, 2007). The report must contain the elements and ensure that an inclusive plan is put in to place to address the root cause of the problem. ASAP's primary purpose is the capture of important information that previously went unreported, to bolster flight safety by eliminating human error and improving man-machine interaction. The additional data is expected to boost the taking of corrective measures before accidents occur (Cann, 2009). Properly implemented and utilized ASAP provides data and information that can be used to enhance safety by directing efforts to revise policies and procedures, and to make changes that are necessary to improve safety. These programs raise safety awareness

within the workforce and build confidence in the environment (Cann, 2009). In the past, air carriers and others may have withheld information from the FAA for fear of punishment and retribution, but when voluntary programs such as ASAP were implemented, information began to flow between the “regulator” and the “regulated,” and benefitted the travelling public. To curtail the use of ASAPs would be regressing to an earlier state of safety awareness and implementation. We all recognize that we now are living with the safest aviation industry of all time. This safe environment was not arrived at by accident, but by cooperation and collaboration (Cann, 2009). When a member of the workforce comes forward and identifies an issue or a concern, or admits a mistake, it should be for the benefit of everyone. It may be to identify a procedural issue or a human factors issue, and the information can be used to make improvements. By eliminating or reducing the use of ASAPs, the workforce is driven “underground” and pertinent information may be withheld that can be used to implement enhancements. The aviation industry has come a long way since these days, and ASAPs have been an important part of that transition (Cann, 2009). We must put differences aside and focus on issues that can, and should, be “negotiated,”—not safety. And we cannot make laws or create obstacles that will detract from providing a safer environment for the travelling public and the workforce. ASAPs provide a true value and benefit for everyone, and we should be working together to tear down obstacles and build trust, not the opposite (Cann, 2009). In all, there are now four types of ASAP -- pilot, mechanic, dispatcher or flight attendant. Companies must have individual agreements with the FAA to participate in any and all (Croft, 2006). Patankar's team interviewed three companies with "successful" ASAPs and three companies "who couldn't get an ASAP launched." The resulting

questionnaire was sent to a large cross section of the aviation maintenance technician community to find out more details about successes and failures, as well as ASAP awareness in general. (Croft, 2006) Patankar defines a successful ASAP as one that:

"has matured to such a level that there is a regular flow of ASAP reports, there are personnel dedicated to maintaining, analyzing and implementing these reports, and there is a mechanism established to provide feedback regarding the overall impacts of the ASAP." "Unsuccessful" meant a program that failed to produce a signed memorandum of understanding between the company, labor union and the FAA. Using information from the six companies, researchers crafted a survey with 104 questions that was sent to 83,000 certified aircraft mechanics from every state in the U.S., out of a total of more than 230,000 mechanics in the FAA's certificate database. Results from the 5,000 completed surveys (1,548 from AMTs at organizations with ASAPs, 2,920 from companies with no ASAPs, and 124 from FAA inspectors) showed a "significantly higher level of trust" between mechanics and their supervisors at companies with successful ASAPs. The questionnaires also revealed that there was "good communication" about the ASAP within those companies as well as a "standardized or well-understood report handling process" (Croft, 2006).

Key findings from the organizations with no ASAPs showed that there was a:

"significantly lower level of trust" between mechanics and their supervisors there.

The team found that AMTs in some cases did not "seem to see a significant

benefit" in having an ASAP, though that could have meant they were satisfied with existing internal error and hazard reporting systems, but also that there was in general a "severe" lack of awareness about ASAPs within those companies. Regardless of the AMT surveyed, researches said there was "no statistically significant difference" between companies with ASAP and those without ASAP. A troubling revelation was that only 40 percent of the 124 FAA examiners that returned surveys thought ASAPs were important; another 40 percent were "somewhat undecided" (Croft, 2006). Overall, a "substantial" proportion of the respondents were "on the fence" regarding the benefits of an ASAP, an indication that "this undecided population will need further proof and convincing that the ASAPs are producing systemic changes without penalizing the reporters" (Croft, 2006).

Potential Improvements

An aviation incident, or a near miss, is any event that could have had bad consequences, but did not. Near misses can range from partial penetration of the defenses to situations in which all the available safeguards were defeated but no actual losses were sustained (Reason, 1997). In other words, they span the gamut from benign events in which one or more of the defenses prevented a potentially bad outcome as planned, to ones that missed being catastrophic by only a hairs breadth. The former provide useful proactive information about system resilience, while the latter are indistinguishable from

fully fledged accidents in all but outcome, and so fall squarely into the reactive camp (Reason, 1997). To reduce risk to an organization, a review has to be completed of prior incidents that the organization has experienced. Safety Risk Management involves identification, analysis and elimination (or mitigation) of hazards that pose an unacceptable level of risk to an organization. We also want to find and treat these hazards before they result in harm instead of waiting for something bad to happen then figuring out how to prevent it from happening again (Hollinger, 2013). This is what is known as proactive risk management instead of a reactive risk management. Safety Risk Management begins by looking at our systems, processes, and procedures to determine how they are intended to perform. And then anticipate and determine how and why they may not they may not perform as needed (Hollinger, 2013).

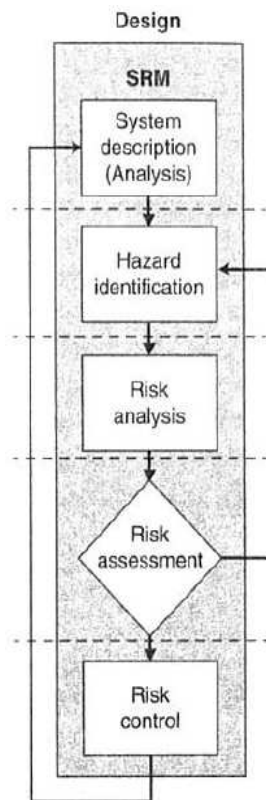


Figure 2. Hollinger Safety Risk Management Design

Hazard identification is the second step that an organization should accomplish. A hazard is defined as a condition or an object with the potential to cause injuries to personnel, damage to equipment or structures, loss of material, or reduction of ability to perform a prescribed function (Hollinger, 2013).

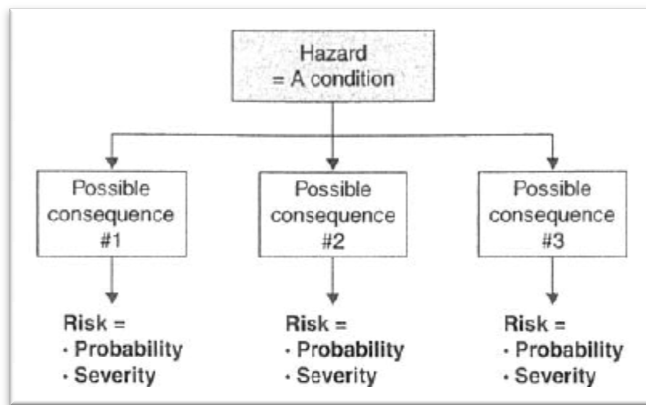


Figure 3. Hollinger Hazard Risk Mitigation

The analysis of multiple events tells us which of many possible processes are the most likely to provide a valid and cost-effective measure of current safety health. An effective reactive technique should give an accurate picture of the weakness and absence that existed in the defenses (Reason, 2007). These ‘snapshots’ reveal the often improbable ways that even the most elaborate defenses can be defeated, Once again, analyses of several events from the same domain can bring to light recurrent, and often surprising, patterns of defenses weakness (Reason, 2007). A hazard is a situation that exists that

decreases the overall level of safety of an operation. Risk is the probability and severity of a consequence resulting from a hazard. It is important to consider both the probability and the severity of the outcome. Just because a credible outcome of a hazard is death does not mean there is a high risk involved (Hollinger, 2013). The next step in the risk analysis is to envision all possible negative penalties or results that could come from a hazard. Severity is another thing to consider when addressing the impact. Severity is the degree of harm that would be caused by the consequence. Consider not only lives that may be lost, but also injuries, property or financial damage, environmental impact, security concerns, regulatory compliance, political implications, and /or media interest (Hollinger, 2013). The advantages of collecting and analyzing information about incidents, accidents, and near misses are clear. If the right conclusions are drawn and acted upon they can work like ‘vaccines’ to mobilize the systems defenses against some more serious occurrence in the future – and, like good vaccines, they do this without damaging anyone or anything in the process. Analyzing incidents provide:

- Qualitative insights into how small defensive failures can line up to create large disasters.
 - The numbers required for more penetrating quantitative analyses because Incidents have a higher occurrence frequency than bad outcomes.
- And, perhaps most importantly, they provide a powerful reminder of the hazards confronting the system and so slow down the process of forgetting to be afraid. But, for this to occur, the data need to be disseminated widely, particularly amount the bean counters in the upper echelons of the organization. The latter have been known to become especially alert when

the information relating to each event includes a realistic estimate of its potential financial cost to the organization. (Reason, 2007)

There are wide variations in the type of information that can be collected from these safety occurrences. Given the proper tools and quantitative methods, information can be retrieved from these events to help prevent future accidents and incidents within the industry.

CHAPTER III

METHODOLOGY

The purpose of this case study of the FAA, Flight Inspection Services Safety Significant Events database from 2009 through 2012 was to discover if there are relationships between a set of independent variables and the dependent variable of a reportable event. The quantitative design utilized was non experimental and categorized failures as independent variables. These independent variables were categorized by Year, Month, Day, Hour, Phase of Flight, Aircraft System, and Fleet Type in which they occurred. This will help determine safety trends of events that occur in flight or on the ground that affect, or could affect, the safety of an FAA aircraft or aircrew member. This will help determine safety trends of events that occur in flight or on the ground that affect, or could affect, the safety of an FAA aircraft or aircrew member. The study should not only benefit the organization by providing a categorical perspective from which future decisions may be enriched, but should also serve as an educational resource to other CFR Part 135 Operators.

Research Questions

The research questions were formulated to understand if certain independent variables resulted in a higher occurrence of reported safety events. The results of the research questions could indicate trends that might assist the organization in identifying activities that have a higher than normal potential for future accidents:

1. Did a specific year represent an increased probability for an accident or incident?
2. Did a specific month represent an increased probability for an accident or incident?
3. Did a specific day represent an increased probability for an accident or incident?
4. Did a specific hour represent an increased probability for an accident or incident?
5. Did a specific aircraft type in the fleet experience a higher number of failures that lead to an accident or incident?
6. Did a specific phase of flight represent an increased probability for an accident or incident?
7. Did a specific aircraft system experience a higher frequency of failures that lead to an accident or incident?

Research Hypotheses

Based on the research questions, a series of research hypotheses were developed:

1. Null Hypothesis (H_01): There will be no significant relationship between the specific year and increased probability for an accident or incident.

Alternative Hypothesis (H_{a1}): There will be a significant relationship between the specific year and increased probability for an accident or incident.

2. Null Hypothesis (H_02): There will be no significant relationship between the specific month and increased probability for an accident or incident.

Alternative Hypothesis (H_{a2}): There will be a significant relationship between the specific month and increased probability for an accident or incident.

3. Null Hypothesis (H_03): There will be no significant relationship between the specific day and increased probability for an accident or incident.

Alternative Hypothesis (H_{a3}): There will be a significant relationship between the specific day and increased probability for an accident or incident.

4. Null Hypothesis (H_04): There will be no significant relationship between the specific hour and increased probability for an accident or incident.

Alternative Hypothesis (H_{a4}): There will be a significant relationship between the specific hour and increased probability for an accident or incident.

5. Null Hypothesis (H_05): There will be no significant relationship between a specific aircraft type and frequency of failures that lead to an accident or incident.

Alternative Hypothesis (H_a5): There will be a significant relationship between a specific aircraft type and frequency of failures that lead to an accident or incident.

6. Null Hypothesis (H_06): There will be no significant relationship between a specific phase of flight and frequency of failures that lead to an accident or incident.

Alternative Hypothesis (H_a6): There will be a significant relationship between a specific phase of flight and frequency of failures that lead to an accident or incident.

7. Null Hypothesis (H_07): There will be no significant relationship between a specific aircraft system and frequency of failures that lead to an accident or incident.

Alternative Hypothesis (H_a7): There will be a significant relationship between a specific aircraft system and frequency of failures that lead to an accident or incident.

Research Design

The study was performed as a categorical, quantitative assessment of the Federal Aviation Administration Flight Inspections Services Safety Significant Events database

from the 2009 through 2012 timeframe. The study extracted time of event and system failure data contained within the Safety Reports to arrive at its findings.

Sample Selection

The sample of this study was restricted to a deliberate examination of safety significant reports that occurred within the Flight Inspection Services between calendar year 2009 through 2012. These reports were sourced from Federal Government employees who were stationed in Oklahoma City, Oklahoma; Atlanta, Georgia; Battle Creek, Michigan; Atlantic City, New Jersey; Sacramento, California; and Anchorage, Alaska. No other safety reports or information were used in this research. This sample was selected because the Safety Significant Event program was originally established in 2008; and it was determined first year results would likely contain errors or omissions as the crew members became familiar with the reporting process. The sample ended at the closure of calendar year 2012 to ensure that four complete years of data were recorded to get an accurate representation of the program's steady state operation. No Safety forms during the specified time frame were excluded from this study; all of the submitted reports were used in their entirety.

Reliability

A data collection instrument was not utilized in this study. The researcher mined data directly from the Safety Significant Events Reports Database maintained by the

United States Federal Government. The research can be systematically tested for reliability using the same data set and statistical procedures defined within the methodology section.

Validity

The study utilized data collected from the Flight Inspection Services Safety Significant Events Database, a data base maintained specifically for the recording of incidents and accidents that affect the organization's operational safety. The Organization used standardized criteria and definitions in designing the reports that are contained in its database as defined in 49 CFR Part 830. Because the study was non experimental and all the reports were used; the study avoids the threats to validity of experimental design as outlined by Creswell (Creswell, 2007, p. 303). Threats to validity refer to specific reasons for why we can be wrong when we make an inference in an experiment because of covariance, causation constructs, or whether the causal relationship holds over variations in persons, setting, treatments, and outcomes (Shadish, Cook, & Campbell, 2002). The four types of validity are:

- Statistical conclusion validity, which refers to the appropriate use of statistics (e.g., violating statistical assumptions, restricted range on a variable, low power) to infer whether the presumed independent and dependent variables vary in the experiment.
- Construct validity, which means the validity of inferences about the constructs (or variables) in the study.

- Internal validity, which relates to the validity of inferences drawn about the cause and effect relationship between the independent and dependent variables.
- External validity, which refers to the validity of the cause-and-effect relationship being generalizable to other persons, settings, treatment variables, and measures
(Creswell, 2007, p. 303).

Data Gathering Procedures

Data for this study was requested in February of 2013 via the Freedom of Information Act submitted through Federal Aviation Administration, Central Service Area, Air Traffic Organization FOIA Coordinator, AJ02C5, 2601 Meacham Boulevard, Ft. Worth, TX 76193. The requesting letter specified the reports are de-identified to remove Employee User Name, First Name, and Last Name, Aircraft Configuration Nickname, Tail Number and Flight Crew Employee Information Primary Duties during Time of Event. The Safety Significant Events which were requested were in response to an event that occurred in flight or on the ground, other than an aircraft accident or incident as defined in 49 CFR Part 830, which affected or could affect the safety of an FAA aircraft or aircrew member. In addition, any use of the abnormal or emergency checklist required an SSE report.

Freedom of Information Act (FOIA) Request 2013-2907 was fulfilled by the Central Service Area on February 26th, 2013. The data set included all 185 individual

Safety Significant Event reports from the 2009 through 2012 time period. The Federal Aviation Administration removed all personally identifiable information from the reports prior to fulfillment.

Institutional Review Board Compliance

Oklahoma State University Institutional Review Board reviewed the procedures and data enclosed in this study for compliance with the protection of human subjects. The researcher requested all data received from the Federal Aviation Administration to be de-identified of personally identifiable information. The researcher provided all of the received documentation to the Institutional Review Board and was granted an exception in September 2013.

Data Types

The statistical procedures used two groupings of data. The independent variables used nominal scale data, each identified by the category. The categories were Year, Month, Day, Hour, Phase of Flight, Aircraft System, and Fleet Type. An independent variable is an attribute or characteristic that influences or affects an outcome or dependent variable. Independent variable influences the dependent variable through the intervening variable. Researchers study independent variables to see what effect or influence they have on the outcome. (Creswell, p. 116, 2007) The dependent variable for the study was the reported event that generated the Safety Significant Event Report.

Data Removal

All personally identifiable data was removed by the Federal Aviation Administration prior to fulfillment. In addition to the requested information, the Safety Significant Reports received from the Federal Aviation Administration contained other data fields that were not relevant to this study. Subsequently the data that was not relevant to the study was removed from the analysis. Refer to Figure 3.1 in appendix for redacted data not used.

Statistical Tools

The Statistical Package for the Social Sciences (SPSS) computer software was utilized for all the descriptive statistical presentations, modeling, and statistical analysis. The charts displayed in this study were modeled with SPSS or Microsoft Excel software.

Statistical Procedures

Descriptive statistics were utilized during this study to examine the data contained within the Safety Significant Reports. Descriptive statistics is the term given to the analysis of data that helps describe, show or summarize data in a meaningful way such that, for example, patterns might emerge from the data. Descriptive statistics do not, however, allow us to make conclusions beyond the data we have analyzed or reach

conclusions regarding any hypotheses we might have made. They are simply a way to describe our data. (Laerd, 2014) Descriptive statistics are very important because if we simply presented our raw data it would be hard to visualize what the data was showing, especially if there was a lot of it. Descriptive statistics therefore enable us to present the data in a more meaningful way, which allows simpler interpretation of the data (Laerd, 2014). To further understand the data measures of central tendency such as mode, median, and mean were utilized. Measures of central tendency are ways of describing the central position of a frequency distribution for a group of data. In this case, the frequency distribution is simply the distribution and pattern ("Descriptive and inferential," 2013). In addition measures of spread were utilized; measures of spread help us to summarize how spreads out these scores are. To describe this spread, a number of statistics are available to us, including the range, quartiles, absolute deviation, variance and standard deviation ("Descriptive and inferential," 2013). The findings of this statistical analysis will be reviewed in Chapter IV.

Chi-Square Procedures

The chi-square test is used to determine whether there is a significant difference between the expected frequencies and the observed frequencies in one or more categories. Do the number of individuals or objects that fall in each category differ significantly from the number you would expect (Sharp, 2014) Is this difference between the expected and observed due to sampling error, or is it a real difference? When you find the value for chi square, you determine whether the observed frequencies differ

significantly from the expected frequencies (Sharp, 2014). After the researcher determines the chi-square value, they must also determine whether the observed frequencies change significantly from the expected frequencies. The significance level for this research is set at a 95% or P Value $> .05$ confidence level that the difference is not due to chance. All of the requirements to utilize a Chi-Square were met and no exemptions were used for this study.

The requirements for the Chi-Square Test (Sharp, 2014)

1. Quantitative data.
2. One or more categories.
3. Independent observations.
4. Adequate sample size (at least 10).
5. Simple random sample.
6. Data in frequency form.
7. All observations must be used

CHAPTER IV

FINDINGS

The following research findings are laid out by the Year, Month, Day, Hour, Fleet Type, Phase of Flight, and Aircraft System, in which they occurred. To understand the data, the researcher utilized the mean, median, mode, and standard deviation for each dataset. The Mean was an average of the data. The Median was the middle value that occurred in stringing the data from least to most occurrences. The Mode is a list of numbers that occurred most frequently in the data set. The standard deviation is the amount of change between each in relation to the mean. Descriptive statistics will help summarize the overall trends or tendencies in data, provide an understanding of how varied scores might be, and provide insight into where one score stands in comparison with others (Creswell, 2007). The hypotheses were then tested with a Chi-Square of $p > 0.05$ to determine its significance to the increased probability for an accident or incident.

Year

The data set contained (N = 185) Safety Significant Reports that spanned a 4 year period from 2009 through 2012. Data distribution observed 35 reports in 2009, 55 reports in 2010, 42 reports in 2011, and 53 reports in 2012. An analysis of the yearly SSE distribution can be found in the graphs below (Table 1). The data provided a year mean value of 2010 (55 occurrences), Median year value of 2011 (42 occurrences), Mode value 2010 (55 occurrences), and the Standard Deviation of 1.093. (Table 2)

1. Null Hypothesis (Ho1): There will be no significant relationship between the specific year and increased probability for an accident or incident.

Alternative Hypothesis (Ha1): There will be a significant relationship between the specific year and increased probability for an accident or incident.

The results of the Chi-Square (Table 3 and 4) indicated that it was statistically probable at .123 that the yearly results happened by chance.

YEAR

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid				
2009	35	18.9	18.9	18.9
2010	55	29.7	29.7	48.6
2011	42	22.7	22.7	71.4
2012	53	28.6	28.6	100.0
Total	185	100.0	100.0	

Table 1. *SPSS Reporting by Year*

YEAR

N	Valid	185
	Missing	0
Mean		2010
Median		2011
Mode		2010
Std. Deviation		1.093

Table 2. *SPSS Reporting by Year Descriptive*

YEAR

	Observed N	Expected N	Residual
2009	35	46.3	-11.3
2010	55	46.3	8.8
2011	42	46.3	-4.3
2012	53	46.3	6.8
Total	185		

Table 3. *SPSS Reporting by Year Expected*

Test Statistics

	YEAR
Chi-Square	5.768 ^a
df	3
Asymp. Sig.	.123

Table 4. SPSS Reporting by Year Test Statics

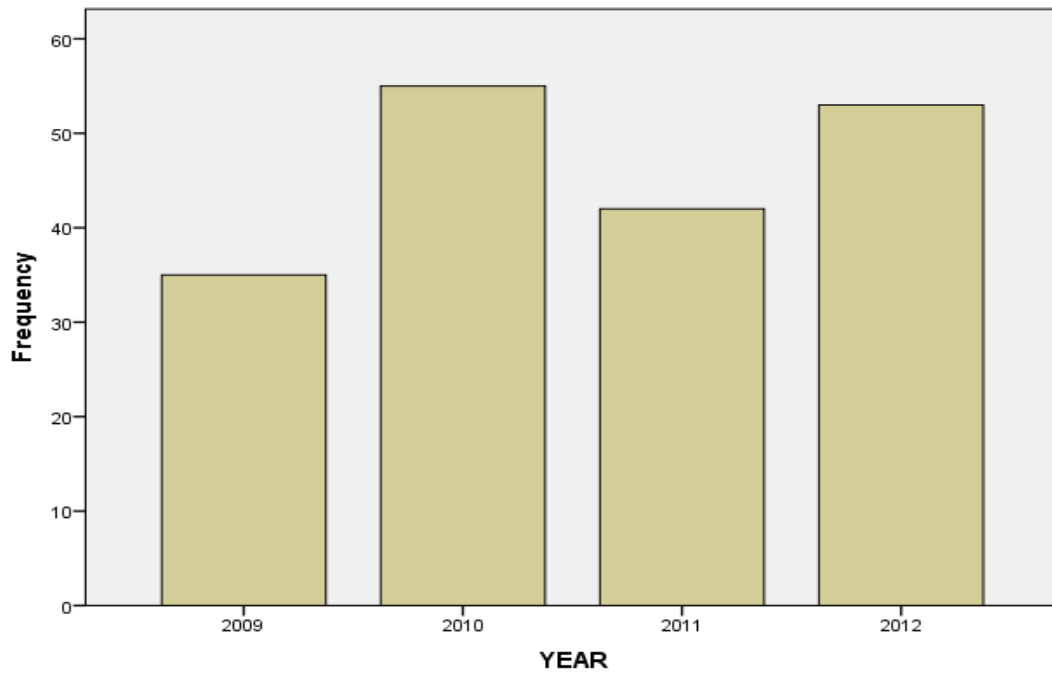


Table 5. SPSS Reporting by Year Frequency

Month

The data set contained (N = 185) Safety Significant Reports that spanned the 12 month period over the course of a calendar year. Data distribution observed January recorded 15 reports which accounted for 8.1 percent of the total. February recorded 23 reports which accounted for 12.4 percent of the total. March recorded 15 reports which accounted for 8.1 percent of the total. April recorded 20 reports in which accounted for 10.8 percent of the total. May recorded 14 reports in which accounted for 7.6 percent of the total. June recorded 4 reports in which accounted for 2.2 percent of the total. July recorded 6 reports which accounted for 3.2 percent of the total. August recorded 20 reports in which accounted for 10.8 percent of the total. September recorded 13 reports which accounted for 7.0 percent of the total. October recorded 24 reports in which accounted 13.0 percent of the total. November recorded 15 reports which accounted for 8.1 percent of the total. December recorded 16 reports which accounted for 8.6 percent of the total. An analysis of the monthly SSE distribution can be found in the (Table 6). The data provided a month Mean value of 6.46 or June, Median month value of 7 or July, Mode month value of 10 or October, and a Standard Deviation of 3.664 (Table 7).

2. Null Hypothesis (Ho2): There will be no significant relationship between the specific month and increased probability for an accident or incident.

Alternative Hypothesis (Ha2): There will be a significant relationship between the specific month and increased probability for an accident or incident.

The results of the Chi-Square (Table 8 and 9) indicated that it was statistically improbable at .006 that the monthly results happened by chance.

MONTH

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid				
1-JAN	15	8.1	8.1	8.1
2- FEB	23	12.4	12.4	20.5
3- MAR	15	8.1	8.1	28.6
4-APR	20	10.8	10.8	39.5
5-MAY	14	7.6	7.6	47.0
6-JUN	4	2.2	2.2	49.2
7-JUL	6	3.2	3.2	52.4
8-AUG	20	10.8	10.8	63.2
9-SEP	13	7.0	7.0	70.3
10-OCT	24	13.0	13.0	83.2
11-NOV	15	8.1	8.1	91.4
12-DEC	16	8.6	8.6	100.0
Total	185	100.0	100.0	

Table 6. SPSS Reporting by Month

MONTH

N	Valid	185
	Missing	0
Mean		6.46
Median		7.00
Mode		10
Std. Deviation		3.664

Table 7. SPSS Reporting by Month Descriptive

MONTH

	Observed N	Expected N	Residual
1-JAN	15	15.4	-.4
2-FEB	23	15.4	7.6
3-MAR	15	15.4	-.4
4-APR	20	15.4	4.6
5-MAY	14	15.4	-1.4
6-JUN	4	15.4	-11.4
7-JUL	6	15.4	-9.4
8-AUG	20	15.4	4.6
9-SEP	13	15.4	-2.4
10-OCT	24	15.4	8.6
11-NOV	15	15.4	-.4
12-DEC	16	15.4	.6
Total	185		

Table 8. SPSS Reporting by Month Expected

Test Statistics

	MONTH
Chi-Square	26.005 ^a
df	11
Asymp. Sig.	.006

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 15.4.

Table 9. *SPSS Reporting by Month Test Statics*

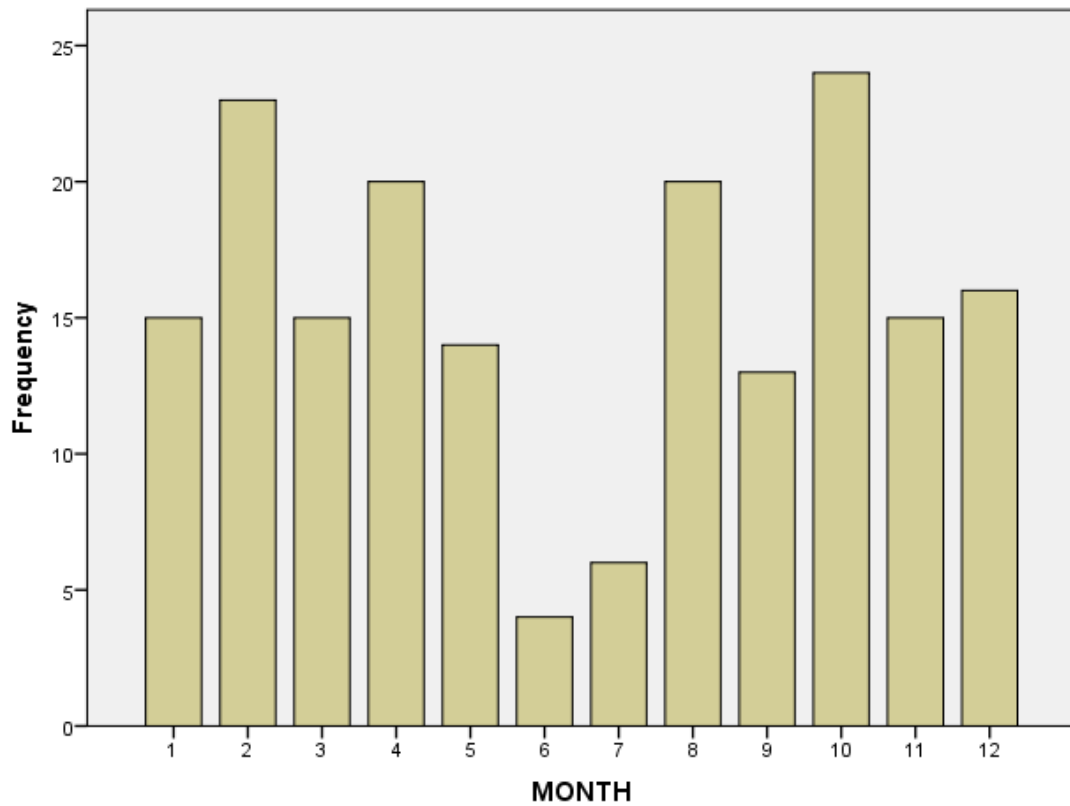


Table 10. *SPSS Reporting by Month Frequency*

Day

The data set contained (N = 185) Safety Significant Reports that spanned the 7 day period over the course of a week. Data distribution observed Sunday reported 3 occurrences which accounted for 1.6 percent of the total. Monday reported 23 occurrences which accounted for 12.4 percent of the total. Tuesday reported 37 occurrences which accounted for 20.0 percent of the total. Wednesday reported 37 occurrences which accounted for 20.0 percent of the total. Thursday reported 51 occurrences which accounted for 27.6 percent of the total. Friday reported 29 occurrences which accounted for 15.7 percent of the total. Saturday reported 5 occurrences which accounted for 2.7 percent of the total. An analysis of the Daily SSE distribution can be found in the (Table 11). The data provided a daily mean value of 4.17 or Thursday, Median daily value of 4 or Thursday, Mode daily value of 5 or Friday, and a Standard Deviation of 1.404 (Table 12).

3. Null Hypothesis (Ho3): There will be no significant relationship between the specific day and increased probability for an accident or incident.

Alternative Hypothesis (Ha3): There will be a significant relationship between the specific day and increased probability for an accident or incident.

The results of the Chi-Square (Figure 13 and 14) indicated that it was statistically improbable at .000 that the daily results happened by chance.

		DAY			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-SUN	3	1.6	1.6	1.6
	2-MON	23	12.4	12.4	14.1
	3-TUE	37	20.0	20.0	34.1
	4-WED	37	20.0	20.0	54.1
	5-THU	51	27.6	27.6	81.6
	6-FRI	29	15.7	15.7	97.3
	7-SAT	5	2.7	2.7	100.0
	Total	185	100.0	100.0	

Table 11. *SPSS Reporting by Day*

		DAY
N	Valid	185
	Missing	0
Mean		4.17
Median		4.00
Mode		5
Std. Deviation		1.404

Table 12. *SPSS Reporting by Day Descriptive*

DAY

	Observed N	Expected N	Residual
1-SUN	3	26.4	-23.4
2-MON	23	26.4	-3.4
3-TUE	37	26.4	10.6
4-WED	37	26.4	10.6
5-THU	51	26.4	24.6
6-FRI	29	26.4	2.6
7-SAT	5	26.4	-21.4
Total	185		

Table 13. *SPSS Reporting by Day Expected*

Test Statistics

	DAY
Chi-Square	70.141 ^a
df	6
Asymp. Sig.	.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 26.4.

Table 14. *SPSS Reporting by Day Test Statics*

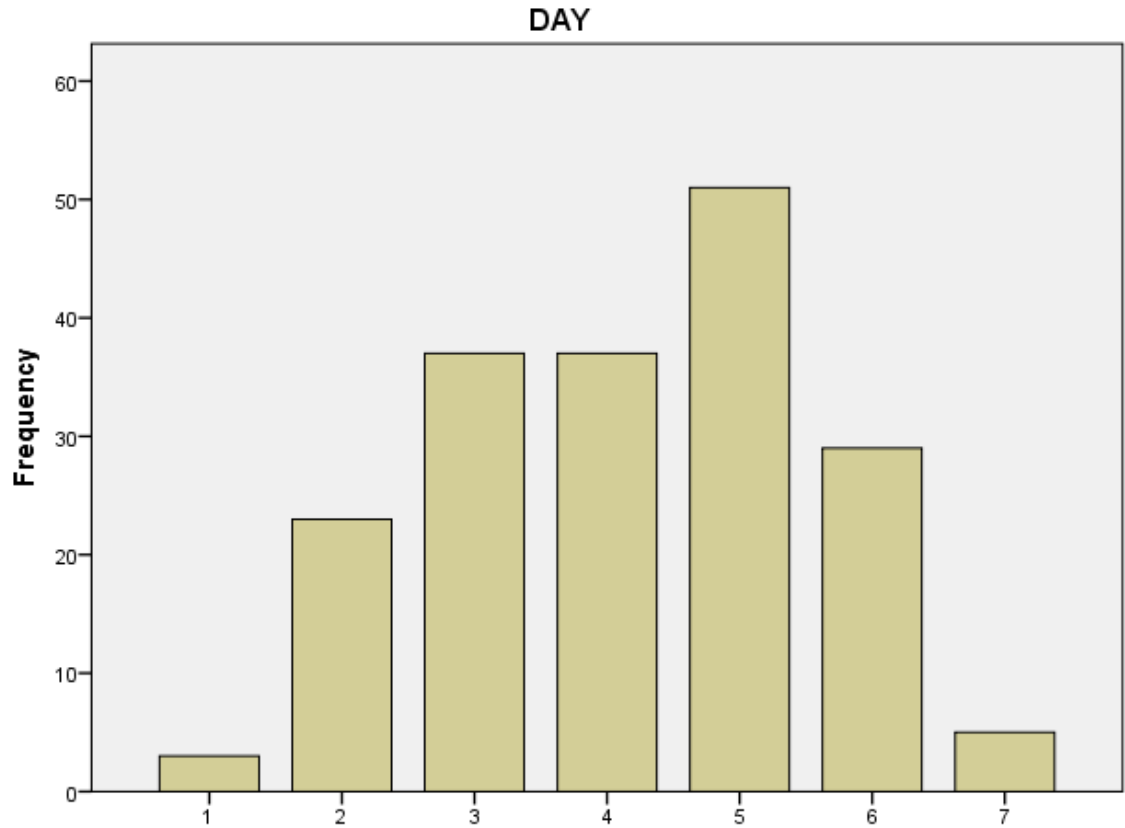


Table 15. *SPSS Reporting by Day Frequency*

Local Time

The data set contained (N = 185) Safety Significant Reports that spanned the military 24 hour time period over the course of a day. Data distribution observed 00:00 reported 15 occurrences that did not state a specific time and accounted for 8.1 percent of the total. 01:00 reported 1 occurrence which accounted for 0.5 percent of the total. 02:00 reported 3 occurrences which accounted for 1.6 percent of the total. 03:00 reported 4 occurrences which accounted for 1.1 percent of the total. 04:00 reported 2 occurrences

which accounted for 1.1 percent of the total. 05:00 reported 1 occurrence which accounted for 0.5 percent of the total. 06:00 reported 2 occurrences which accounted for 1.1 percent of the total. 07:00 reported 3 occurrences which accounted for 1.6 percent of the total. 08:00 reported 9 occurrences which accounted for 4.9 percent of the total. 09:00 reported 20 occurrences which accounted for 10.8 percent of the total. 10:00 reported 16 occurrences which accounted for 8.6 percent of the total. 11:00 reported 20 occurrences which accounted for 10.8 percent of the total. 12:00 reported 9 occurrences which accounted for 4.9 percent of the total. 13:00 reported 13 occurrences which accounted for 7.0 percent of the total. 14:00 reported 15 occurrences which accounted for 8.1 percent of the total. 15:00 reported 14 occurrences which accounted for 7.6 percent of the total. 16:00 reported 9 occurrences which accounted for 4.9 percent of the total. 17:00 reported 4 occurrences which accounted for 2.2 percent of the total. 18:00 reported 3 occurrences which accounted for 1.6 percent of the total. 19:00 reported 4 occurrences which accounted for 2.2 percent of the total. 20:00 reported 6 occurrences which accounted for 3.2 percent of the total. 21:00 reported 4 occurrences which accounted for 2.2 percent of the total. 22:00 reported 6 occurrences which accounted for 3.2 percent of the total. 23:00 reported 2 occurrences which accounted for 1.1 percent of the total.

(Table 15).

An analysis of the Hourly Local Time SSE distribution can be found in the (Table 16).

The data provided an hourly mean value of 11.45 or 11:00, Median hourly value of 11 or 11:00, Mode hourly value of 9 or 09:00, and a Standard Deviation of 5.65 (Table 17).

4. Null Hypothesis (Ho4): There will be no significant relationship between the specific hour and increased probability for an accident or incident.

Alternative Hypothesis (Ha4): There will be a significant relationship between the specific hour and increased probability for an accident or incident.

The results of the Chi-Square (Table 18 and 19) indicated that it was statistically improbable at .000 that the hourly results happened by chance.

LOCAL

	HOUR	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	15	8.1	8.1	8.1
	1	1	.5	.5	8.6
	2	3	1.6	1.6	10.3
	3	4	2.2	2.2	12.4
	4	2	1.1	1.1	13.5
	5	1	.5	.5	14.1
	6	2	1.1	1.1	15.1
	7	3	1.6	1.6	16.8
	8	9	4.9	4.9	21.6
	9	20	10.8	10.8	32.4
	10	16	8.6	8.6	41.1
	11	20	10.8	10.8	51.9
	12	9	4.9	4.9	56.8
	13	13	7.0	7.0	63.8
	14	15	8.1	8.1	71.9
	15	14	7.6	7.6	79.5
	16	9	4.9	4.9	84.3
	17	4	2.2	2.2	86.5
	18	3	1.6	1.6	88.1
	19	4	2.2	2.2	90.3
20	6	3.2	3.2	93.5	

21	4	2.2	2.2	95.7
22	6	3.2	3.2	98.9
23	2	1.1	1.1	100.0
Total	185	100.0	100.0	

Table 16. *SPSS Reporting by Local Time*

LOCAL

N	Valid	185
	Missing	0
Mean		11.45
Median		11.00
Mode		9 ^a
Std. Deviation		5.652

a. Multiple modes exist. The smallest value is shown

Table 17. *SPSS Reporting by Local Time Descriptive*

LOCAL

HOURL	Observed N	Expected N	Residual
0	15	7.7	7.3
1	1	7.7	-6.7
2	3	7.7	-4.7
3	4	7.7	-3.7
4	2	7.7	-5.7
5	1	7.7	-6.7
6	2	7.7	-5.7
7	3	7.7	-4.7
8	9	7.7	1.3
9	20	7.7	12.3
10	16	7.7	8.3
11	20	7.7	12.3
12	9	7.7	1.3
13	13	7.7	5.3
14	15	7.7	7.3
15	14	7.7	6.3
16	9	7.7	1.3
17	4	7.7	-3.7
18	3	7.7	-4.7
19	4	7.7	-3.7
20	6	7.7	-1.7
21	4	7.7	-3.7

22	6	7.7	-1.7
23	2	7.7	-5.7
Total	185		

Table 18. *SPSS Reporting by Local Time Expected*

Test Statistics

	LOCAL
Chi-Square	112.211 ^a
df	23
Asymp. Sig.	.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 7.7.

Table 19. *SPSS Reporting by Local Time Statics*

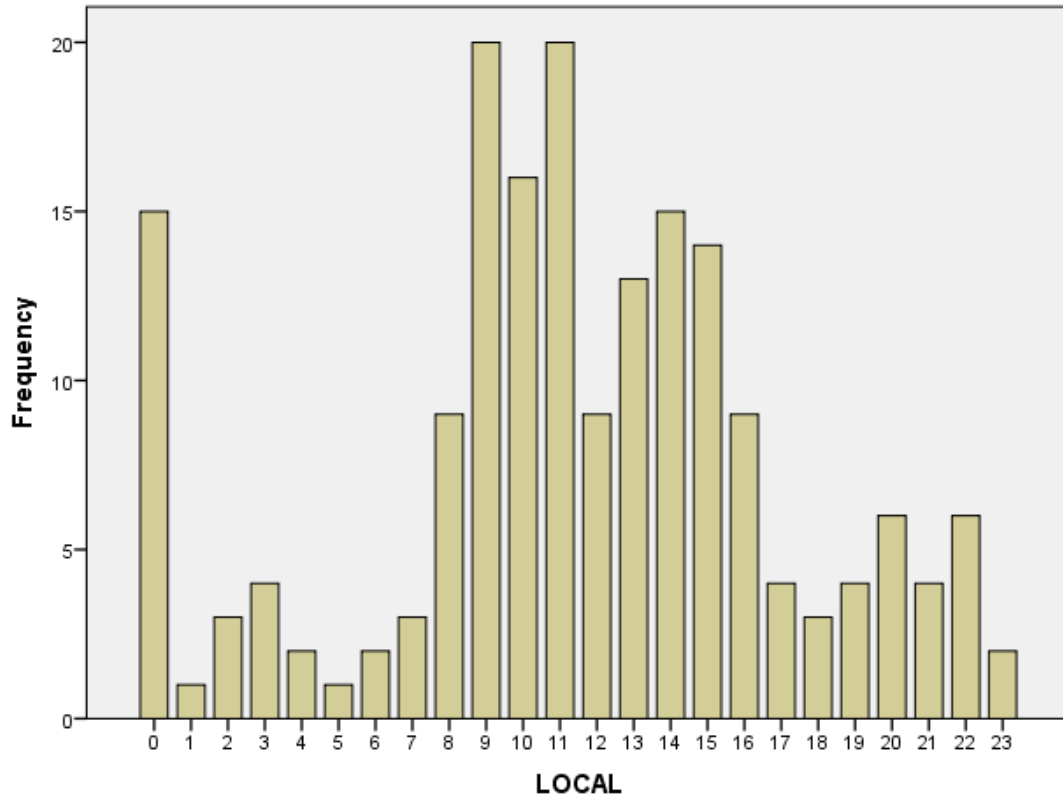


Table 20. *SPSS Reporting by Local Time Frequency*

Aircraft Type

The data set contained (N = 185) Safety Significant Reports that spanned the 5 types of aircraft the organization operates. Data distribution observed Beechcraft 300 reported 124 occurrences which accounted for 67.0 percent of the total. Lear 60 reported 29 occurrences which accounted for 15.7 percent of the total. Challenger 601 reported 30 occurrences which accounted for 16.2 percent of the total. Challenger 604 reported 1 occurrence which accounted for 0.5 percent of the total. Challenger 605 reported 1 occurrence which accounted for 0.5 percent of the total. An analysis of the Aircraft Type

SSE distribution can be found in the (Table 21). The data provided an aircraft mean value of 1.52 or Beechcraft 300, Median aircraft value of 1 or Beechcraft 300, Mode aircraft value of 1 or Beechcraft 300, and a Standard Deviation of 0.822 (Table 22).

5. Null Hypothesis (Ho6): There will be no significant relationship between a specific aircraft type and frequency of failures that lead to an accident or incident.

Alternative Hypothesis (Ha6): There will be a significant relationship between a specific aircraft type and frequency of failures that lead to an accident or incident.

The results of the Chi-Square (Table 23 and 24) indicated that it was statistically improbable at .006 that the aircraft type results happened by chance.

AVALUE					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-BE300	124	67.0	67.0	67.0
	2-LR60	29	15.7	15.7	82.7
	3-C601	30	16.2	16.2	98.9
	4-C604	1	.5	.5	99.5
	5-C605	1	.5	.5	100.0
	Total	185	100.0	100.0	

Table 21. *SPSS Reporting by Aircraft Type*

AVALUE		
N	Valid	185
	Missing	0
Mean		1.52
Median		1.00
Mode		1
Std. Deviation		.822

Table 22. SPSS Reporting by Aircraft Type Descriptive

AVALUE			
	Observed N	Expected N	Residual
1-BE300	124	37.0	87.0
2-LR60	29	37.0	-8.0
3-C601	30	37.0	-7.0
4-C604	1	37.0	-36.0
5-C605	1	37.0	-36.0
Total	185		

Table 23. SPSS Reporting by Aircraft Type Expected

Test Statistics	
	AVALUE
Chi-Square	277.676 ^a
df	4
Asymp. Sig.	.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 37.0.

Table 24. SPSS Reporting by Aircraft Type Statics

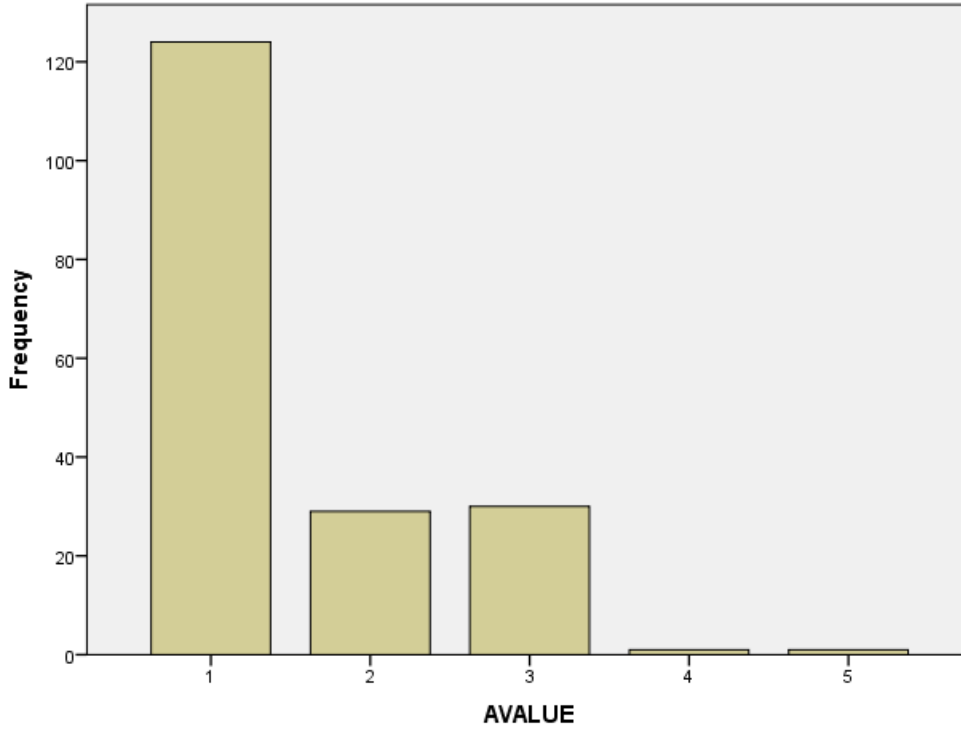


Table 25. *SPSS Reporting by Aircraft Type Frequency*

Phase of Flight

The data set contained (N = 185) Safety Significant Reports that spanned the 8 phase of flight categories. Data distribution observed Approach reported 9 occurrences which accounted for 4.9 percent of the total. Climb reported 2 occurrences which accounted for 1.1 percent of the total. Cruise reported 55 occurrences which accounted for 29.7 percent of the total. Go Around reported 2 occurrences which accounted for 1.1 percent of the total. Ground reported 26 occurrences which accounted for 14.1 percent of the total. Holding reported 8 occurrences which accounted for 4.3 percent of the total.

Landing reported 44 occurrences which accounted for 23.8 percent of the total. Takeoff reported 39 occurrences which accounted for 21.1 percent of the total.

An analysis of the Phase of Flight SSE distribution can be found in the (Table 26). The data provided a phase of flight mean value of 5.32 or Ground, Median value of 5 or Ground, Mode value of 3 or Cruise, and a Standard Deviation of 2.212 (Table 27).

7. Null Hypothesis (Ho7): There will be no significant relationship between a specific phase of flight and frequency of failures that lead to an accident or incident.

Alternative Hypothesis (Ha7): There will be a significant relationship between a specific phase of flight and frequency of failures that lead to an accident or incident.

The results of the Chi-Square (Table 28 and 29) indicated that it was statistically improbable at .000 that the phase of flight results happened by chance.

		PVALUE			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-TAKEOFF	39	21.1	21.1	100.0
	2-CLIMB	2	1.1	1.1	5.9
	3-CRUISE	55	29.7	29.7	35.7
	4-HOLDING	8	4.3	4.3	55.1
	5-APPROACH	9	4.9	4.9	4.9
	6-GOAROUND	2	1.1	1.1	36.8
	7-LANDING	44	23.8	23.8	78.9
	8-GROUND	26	14.1	14.1	50.8
	Total	185	100.0	100.0	

Table 26. *SPSS Reporting by Phase Type*

Statistics		
PVALUE		
N	Valid	185
	Missing	0
Mean		4.39
Median		3.00
Std. Deviation		2.569

Table 27. *SPSS Reporting by Phase Type Descriptive*

PVALUE

	Observed N	Expected N	Residual
1-APPROACH	9	23.1	-14.1
2-CLIMB	2	23.1	-21.1
3-CRUISE	55	23.1	31.9
4-GOAROUND	2	23.1	-21.1
5-GROUND	26	23.1	2.9
6-HOLDING	8	23.1	-15.1
7-LANDING	44	23.1	20.9
8-TAKEOFF	39	23.1	15.9
Total	185		

Table 28. SPSS Reporting by Phase Type Expected

Test Statistics

	PVALUE
Chi-Square	131.151 ^a
df	7
Asymp. Sig.	.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 23.1.

Table 29. SPSS Reporting by Phase Type Statics

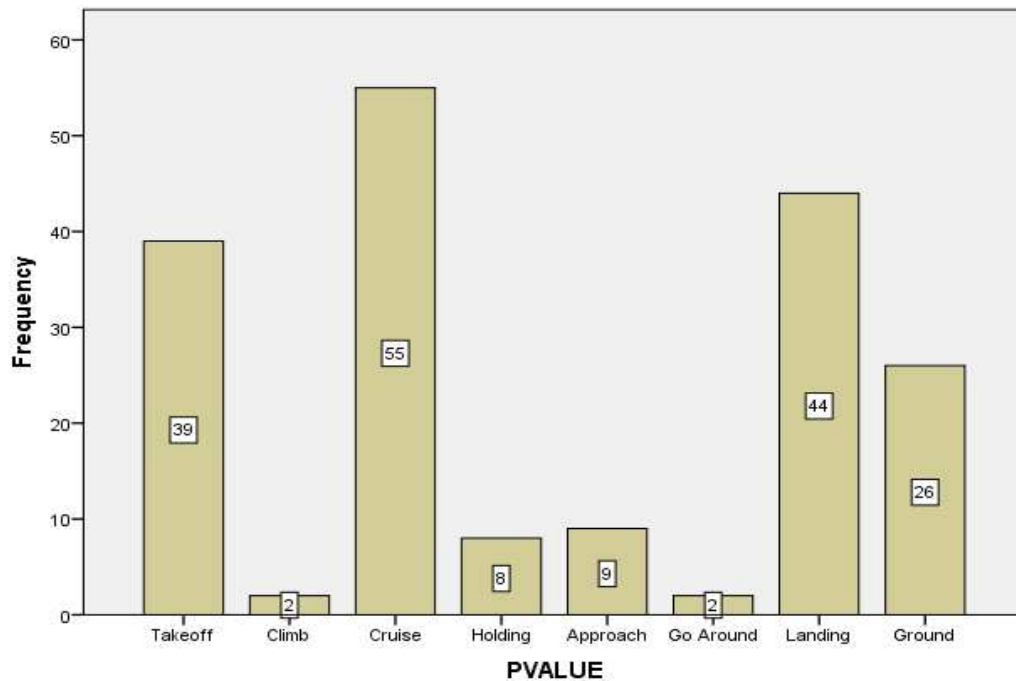


Table 30. SPSS Reporting by Phase Type Frequency

Aircraft System

The data set contained (N = 185) Safety Significant Reports that spanned the 7 Aircraft System categories. Data distribution observed:

Avionics reported 1 occurrence which accounted for 0.5 percent of the total. Electrical reported 28 occurrences which accounted for 15.1 percent of the total. Environmental reported 38 occurrences which accounted for 20.5 percent of the total. Flight Controls reported 13 occurrences which accounted for 7.0 percent of the total. Landing reported 26 occurrences which accounted for 14.1 percent of the total. Mission Equipment reported 40 occurrences which accounted for 21.6 percent of the total. Power Plant reported 39 occurrences which accounted for 21.1 percent of the total.

An analysis of the Aircraft System SSE distribution can be found in the (Table 31). The data provided an aircraft system mean value of 4.68 or Flight Controls, Median value of 5 or Landing, Mode value of 6 or Mission equipment, and a Standard Deviation of 1.821 (Table 32).

7. Null Hypothesis (Ho5): There will be no significant relationship between a specific aircraft system and frequency of failures that lead to an accident or incident.

Alternative Hypothesis (Ha5): There will be a significant relationship between a specific aircraft system and frequency of failures that lead to an accident or incident.

The results of the Chi-Square (Table 33 and 34) indicated that it was statistically improbable at .000 that the aircraft system results happened by chance.

		SVALUE			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-AVIONICS	1	.5	.5	.5
	2-ELECTIRCAL	28	15.1	15.1	15.7
	3-ENVIROMENTAL	38	20.5	20.5	36.2
	4-FLTCONTR	13	7.0	7.0	43.2
	5LANDING	26	14.1	14.1	57.3
	6-MISSEQUIP	40	21.6	21.6	78.9
	7-PWRPLANT	39	21.1	21.1	100.0
	Total	185	100.0	100.0	

Table 31. *SPSS Reporting by System Type*

		Statistics
SVALUE		
N	Valid	185
	Missing	0
Mean		4.68
Median		5.00
Mode		6
Std. Deviation		1.821

Table 32. *SPSS Reporting by System Type Descriptive*

SVALUE

	Observed N	Expected N	Residual
1-AVIONICS	1	26.4	-25.4
2-ELECTRICAL	28	26.4	1.6
3-ENVIROMENTAL	38	26.4	11.6
4-FLTCONTROLS	13	26.4	-13.4
5-LANDING	26	26.4	-.4
6-MISSEQUIP	40	26.4	13.6
7-POWERPLANT	39	26.4	12.6
Total	185		

Table 33. *SPSS Reporting by System Type Expected*

Test Statistics

	SVALUE
Chi-Square	49.405 ^a
df	6
Asymp. Sig.	.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 26.4.

Table 34. *SPSS Reporting by System Type Statics*

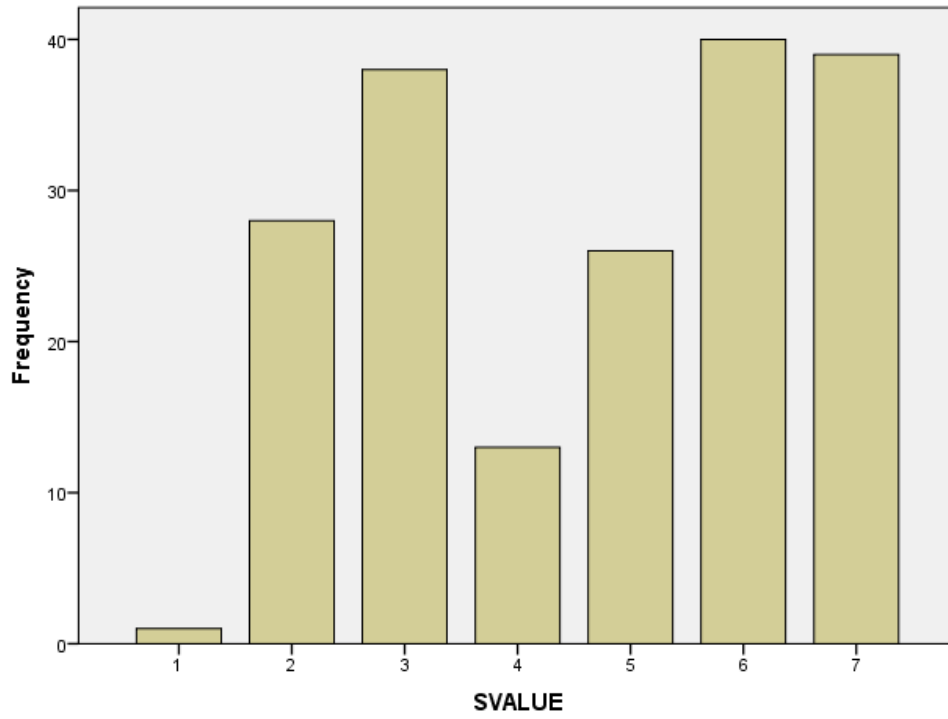


Table 35. *SPSS Reporting by System Type Frequency*

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Summary

This study was conducted to understand the occurrence of Safety Significant Events (SSE) that happened during flight or on the ground that could impact the safety of an FAA aircraft or aircrew member. The study drew upon historical SSE data derived from the Federal Aviation Administration, Flight Inspections Services Safety Significant Events database from the 2009 through 2012 timeframe. As the Flight Inspection Services, Safety Significant Event program entered its eighth year of operation; no formal, objective quantitative study had been conducted of the categorical events to benefit the safety of the organization. This Study set out to determine safety trends of events that occur in flight or on the ground and should benefit the organization by providing a categorical perspective from which future decisions may be enriched, but should also serve as an educational resource to other CFR Part 135 Operators.

The study analyzed and reported Safety Significant Events as they related to Year, Month, Day, Hour, Fleet Type, Phase of Flight, and Aircraft System, in which they occurred. This was done through the use of descriptive statistics and chi-square. Descriptive statistics were used to help describe, show, and summarize data in a meaningful way. Chi-square was utilized to determine whether there was a significant difference between the expected frequencies and the observed frequencies in one or more categories. Significance was determined with the standard of $P > 0.05$. The results of the study's hypothesis testing provide a starting place for future research to occur.

Conclusions

1. Did a specific year represent an increased probability for an accident or incident?

Null Hypothesis (Ho1): There will be no significant relationship between the specific year and increased probability for an accident or incident.

Alternative Hypothesis (Ha1): There will be a significant relationship between the specific year and increased probability for an accident or incident.

Hypothesis 1 Conclusion:

Hypothesis 1 testing concluded that yearly SSE distribution provided a year mean value of 2010 (55 occurrences), Median year value of 2011 (42 occurrences), Mode value 2010 (55 occurrences), and the Standard Deviation of 1.093. The results of the Chi-Square indicated that it was statistically probable at 0.123 that the yearly results happened by chance. The researcher accepted the Null Hypothesis and rejected the Alternative Hypothesis. It can be reasonably concluded that the yearly distribution did occur by chance and there was not a significant relationship between the specific year and increased probability for an accident or incident.

2. Did a specific month represent an increased probability for an accident or incident?

Null Hypothesis (Ho2): There will be no significant relationship between the specific month and increased probability for an accident or incident.

Alternative Hypothesis (Ha2): There will be a significant relationship between the specific month and increased probability for an accident or incident.

Hypothesis 2 Conclusion:

Hypothesis 2 testing concluded that monthly SSE distribution provided a month Mean value of 6.46 or June, Median month value of 7 or July, Mode month value of 10 or October, and a Standard Deviation of 3.664. The results of the Chi-Square indicated that it was statistically improbable at 0.006 that the monthly results happened by chance. The researcher rejected the Null Hypothesis and accepted the Alternative Hypothesis. It can reasonably be concluded that monthly distribution did not occur by chance and some months experienced a higher number of incidents and accidents than other months. For this organization October recorded positive 8.6 and February positive 7.6 from the expected N of 15.4. The lowest occurrence was June with a negative 11.4 from the expected N.

3. Did a specific day represent an increased probability for an accident or incident?

Null Hypothesis (Ho3): There will be no significant relationship between the specific day and increased probability for an accident or incident.

Alternative Hypothesis (Ha3): There will be a significant relationship between the specific day and increased probability for an accident or incident.

Hypothesis 3 Conclusion:

Hypothesis 3 testing concluded the data provided a daily mean value of 4.17 or Thursday, Median daily value of 4 or Thursday, Mode daily value of 5 or Friday, and a Standard Deviation of 1.404. Results of the Chi-Square indicated that it was statistically improbable at .000 that the daily results happened by chance. The researcher rejected the Null Hypothesis and accepted the Alternative Hypothesis. It can reasonably be concluded that daily distribution did not occur by chance and some days experienced a higher number of incidents and accidents than other days of the week. The expected N for the organization was 26.4 occurrences per day. Thursday experienced the higher number of occurrences at positive 24.6 from the expected, while Sunday experienced the least at negative 23.4 from the expected N.

4. Did a specific hour represent an increased probability for an accident or incident?

Null Hypothesis (Ho4): There will be no significant relationship between the specific hour and increased probability for an accident or incident.

Alternative Hypothesis (Ha4): There will be a significant relationship between the specific hour and increased probability for an accident or incident.

Hypothesis 4 Conclusion:

Hypothesis 4 testing concluded the Hourly Local Time SSE distribution provided an hourly mean value of 11.45 or 11:00, Median hourly value of 11 or 11:00, Mode hourly value of 9 or 09:00, and a Standard Deviation of 5.65. The results of the Chi-Square indicated that it was statistically improbable at .000 that the Hourly Local time results happened by chance. The researcher rejected the Null Hypothesis and accepted the Alternative Hypothesis. It can reasonably be concluded that hourly local time distribution did not occur by chance and some hours experienced a higher number of incidents and accidents than other hours of the day. Local time of 09:00 and 11:00 experienced positive movement of 12.3 from the expected N of 7.7. 01:00 and 05:00 experienced the largest negative from the N of 6.7.

5. Did a specific aircraft type in the fleet experience a higher number of failures that lead to an accident or incident?

Null Hypothesis (Ho5): There will be no significant relationship between a specific aircraft type and frequency of failures that lead to an accident or incident.

Alternative Hypothesis (Ha5): There will be a significant relationship between a specific aircraft type and frequency of failures that lead to an accident or incident.

Hypothesis 5 Conclusion:

Hypothesis 5 testing concluded the data provided a phase of flight mean value of 5.32 or Ground, Median value of 5 or Ground, Mode value of 3 or Cruise, and a Standard Deviation of 2.212. Results of the Chi-Square indicated that it was statistically improbable at .000 that the phase of flight results happened by chance. The researcher rejected the Null Hypothesis and accepted the Alternative Hypothesis. It can reasonably be concluded that phase of flight did not occur by chance and some phases of flight result in a higher number of incidents and accidents. The phase of flight that experienced the largest number of occurrences from the expected N of 23.1 was the Cruise phase at positive 31.9. The lowest occurrence that was observed was negative 21.9 during go around and climb.

6. Did a specific phase of flight represent an increased probability for an accident or incident?

Null Hypothesis (Ho6): There will be no significant relationship between a specific phase of flight and frequency of failures that lead to an accident or incident.

Alternative Hypothesis (Ha6): There will be a significant relationship between a specific phase of flight and frequency of failures that lead to an accident or incident.

Hypothesis 6 Conclusion:

Hypothesis 6 testing concluded the data provided an aircraft system mean value of 4.68 or Flight Controls, Median value of 5 or Landing, Mode value of 6 or Mission equipment, and a Standard Deviation of 1.821. Results of the Chi-Square indicated that it was statistically improbable at .000 that the aircraft system results happened by chance. The researcher rejected the Null Hypothesis and accepted the Alternative Hypothesis. It can reasonably be concluded that aircraft system did not occur by chance and some aircraft system result in a higher number of incidents and accidents.

7. Did a specific aircraft system experience a higher frequency of failures that lead to an accident or incident?

Null Hypothesis (Ho7): There will be no significant relationship between a specific aircraft system and frequency of failures that lead to an accident or incident.

Alternative Hypothesis (Ha7): There will be a significant relationship between a specific aircraft system and frequency of failures that lead to an accident or incident.

Hypothesis 7 Conclusion:

Hypothesis 7 testing concluded the data provided an aircraft mean value of 1.52 or Beechcraft 300, Median aircraft value of 1 or Beechcraft 300, Mode aircraft value of 1 or Beechcraft 300, and a Standard Deviation of 0.822. Results of the Chi-Square indicated that it was statistically improbable at .000 that the Aircraft type results happened by chance. The researcher rejected the Null Hypothesis and accepted the Alternative Hypothesis. It can reasonably be concluded that aircraft distribution did not occur by chance and some aircraft experienced a higher number of incidents and accidents than other aircraft in the same fleet. The fleet type had an expected N of 37 with BE-300 experiencing positive 87 and CL-604 and CL-605 experiencing negative 36 from the expected N.

Aviation Stakeholder Recommendations

The following are recommendations compiled from the observations of the researcher. This information could be used as a resource for the organization or an educational tool for other operators for analyzing categorical information specific to their flight program. The study presented numerous opportunities for improvements that Organizations, Safety Departments, and Individual crew members could use to better understand the safety events that they face. The following are in no particular order:

- Perform a Qualitative Study over crew and management perceptions of when they think safety events are occurring by year, month, day, hour, fleet type, phase of flight, and aircraft system and use the data to compare them to the actual occurrences of reported incidents.
- Create site specific safety risk profiles to address the unique safety challenges that different locations within the same organizations face. Update the listing on a yearly basis to respond to changes in the type of events the organization is experiencing.
- Seek to understand when and where the safety events are happening and not rely on General Aviation trends to dictate risk mitigations.
- Assign rolling safety duties to all levels of employees to create awareness, ownership and in-depth knowledge over the safety reporting processes and procedures.

- Survey employees over the effectiveness of safety reporting programs and ask them to provide list of opportunities for improvement on an annual basis.
- Research analytical data over when, why, and where the safety accidents and incidents are happening and share with the organization to create awareness of lesser known dangers.
- Use fact based approach when implementing safety mitigations and provide that data to the pilots and crew members.
- Reoccurring workshops with other flight programs to share observations and lessons learned from peers.
- Obtain access for all employees to review safety data that has been analyzed and compiled to view year by year safety trends. This creates opportunity for new sets of eyes on the data that might notice unseen trends or raise un-asked questions.
- Receive additional training in how to prepare and analyze safety data to create greater understanding of the importance of obtaining descriptive data.
- Employee participation in developing the organizations safety risk profile and determining which fields of data should be on the safety reporting forms to create ownership and understanding.

Recommendations for Additional Research

There is a wealth of data that can be obtained from safety reporting systems if organizations decide to use it. Each field of data presents numerous opportunities for

greater understanding and far greater risk mitigation; this study reviewed a small portion of the overall data contained within the reports. Individually each of the reported variables has enough information contained within that field to create a new study of its own. Some of the hypothetical areas for future research into the specific areas that this study covered are as follows:

Year:

Research could be conducted over why Yearly reports received peak in 2010, fell dramatically in 2011, and then rose again in 2012 to a near peak number. Further research could be conducted to understand if the increase or decrease in the amount of annual safety reports indicates that the organization is getting safer or more complacent with its operation.

Month:

Research could also be conducted over why October and February observed large amounts of Safety Events while the months of June and July had near nominal amounts in comparison to the expected value. Research could examine if this aligned with weather trends in early spring or fall or was there a decline of flight hours flown during the summer months. Other potential areas of research could be into what is happening within the organization during the months of higher occurrence and what mitigations outside the cockpit could be put into place to reduce the number of events.

Day:

Potential areas for further research into Thursday being the largest single day for safety significant events to occur for the organization. Are there more flight hours from for the organization as the week progresses or are there more maintenance problems with the aircraft as the week progresses. Potentially examining if there is intentional deferred maintenance for the airframes until it is convenient for the crews and scheduling.

Hour:

Further research could be conducted as to why is Midnight to 1am the highest spike in occurrences in comparison to other night flying activities. Potential research could also be conducted as to why 9 a.m. and 11 a.m. are the two largest spikes in safety occurrence, what duties were the flight crews performing at those points in time and what could be done to lessen their occurrence.

Aircraft:

Potential research could be conducted on the number of flight hours flown per airframe in comparison to the number of safety significant events. Are some airframes producing higher numbers of safety events at a higher rate than airframes and is there any specific maintenance or operation protocols that could be used to reduce high occurrence tail numbers.

Phase:

Traditionally the largest numbers of safety accidents or incidents are thought to happen during takeoff and landing while the aircraft is transitioning through adverse conditions and environments. Research could be conducted onto why such a large number of occurrences for this organization happened during cruise while the aircraft is in steady state operation.

System:

Research could be conducted to the large number of mission equipment and power plant failures this operator experienced during the 4 year timespan and what could be done to reduce that number. Is it individual pieces of specific equipment that are failing and are their replacements available that could improve the reliability of the airframe.

REFERENCES

- Houston, S. (2014). *Aviation safety action program (asap)*. Retrieved from <http://aviation.about.com/od/Glossary/g/Aviation-Safety-Action-Program-Asap.htm>
- Federal Aviation Administration, Air Transportation Oversight System (ATOS). (2013). *Aviation safety action program (asap)*. Retrieved from website https://www.faa.gov/about/initiatives/atos/air_carrier/asap/
- Federal Aviation Administration, AFS-230. (2002). *Aviation safety action program (asap) (120- 66B)*. Retrieved from website: [http://rgl.faa.gov/Regulatory_and_Guidance_Library/rgAdvisoryCircular.nsf/0/61c319d7a04907a886256c7900648358/\\$FILE/AC120-66B.pdf](http://rgl.faa.gov/Regulatory_and_Guidance_Library/rgAdvisoryCircular.nsf/0/61c319d7a04907a886256c7900648358/$FILE/AC120-66B.pdf)
- Air carrier training systems and voluntary safety programs branch voluntary safety program descriptions*. (2014, May 19). Retrieved from http://www.faa.gov/about/office_org/headquarters_offices/avs/offices/afs/afs200/branches/afs280/descriptions/
- Pratt, D. Federal Aviation Administration, 135 Air Carrier Operations Branch. (2008). *Operational control nava/nbaa frequently asked questions (faqs)*. Retrieved from website: http://www.faa.gov/other_visit/aviation_industry/airline_operators/airline_safety/info/all_infos/media/135op_control_qa.pdf
- Safety management system sms explained*. (2014, July 21). Retrieved from <https://www.faa.gov/about/initiatives/sms/explained/>
- Flight inspection services, ajw-3*. (2014, October 23). Retrieved from https://www.faa.gov/air_traffic/flight_info/avn/
- Descriptive and inferential statistics*. (2013). Retrieved from <https://statistics.laerd.com/statistical-guides/descriptive-inferential-statistics-faqs.php> ("Descriptive and inferential,")
- Anderson, J. (2006). *Qualitative and quantitative research*. Retrieved from http://www.icoe.org/webfm_send/1936

- Creswell, J. (2012). *Planning, conducting, and evaluating quantitative and qualitative research*. (4th ed.). Edwards Brothers, Inc.
- Rosenburg, J. (2014). *The first fatal airplane crash*. Retrieved from <http://history1900s.about.com/od/1900s/a/firstcrash.htm>
- Cellania, M. (2013, March 13). *Orville wright and the first person to die in an airplane*. Retrieved from <http://www.neatorama.com/2013/03/13/Orville-Wright-and-the-First-Person-to-Die-in-an-Airplane/>
- Jackson, K. (2007, Nov 01). *Voluntary disclosure programs*. Retrieved from <http://awin.aviationweek.com/ArticlesStory.aspx?id=fcbc2825-9bb6-4dd3-b499-877eb0cd0fb3>
- Mann, P. (2000, Jan 24). *Wider safety reporting*. Retrieved from <http://awin.aviationweek.com/ArticlesStory.aspx?id=6823cf97-6071-4a3b-8909-9cf3c29b7784>
- Cann, P. (2009, Mar 01). *Survival of asap*. Retrieved from <http://awin.aviationweek.com/ArticlesStory.aspx?id=f71f6a12-c272-43c0-89cf-28d059cbfec6>
- Croft, J. (2006, Aug 01). *Selling maintenance asap*. Retrieved from <http://awin.aviationweek.com/ArticlesStory.aspx?id=880af4c5-527e-4804-954a-55c75f6c463a>
- Jackson, K. (2013, Jun 01). *asap for everyone*. Retrieved from <http://awin.aviationweek.com/ArticlesStory.aspx?id=949ac4da-2b72-49e6-90f5-44a05a529c56>
- Esler, D. (2001, Jan 01). *Assessing the auditors*. Retrieved from <http://awin.aviationweek.com/ArticlesStory.aspx?id=a1c1189e-66d1-4d4e-913c-621d5adc9bde>
- Richfield, P. (2000, Aug 01). *Faa to impose data sharing*. Retrieved from <http://awin.aviationweek.com/ArticlesStory.aspx?id=a16fe85a-11ef-4ddb-80fe-1e4cc8d7a2f2>
- Edwards, L. (2009, Jun 18). *Accidents vs. incidents*. Retrieved from <http://www.aviationpros.com/article/10374517/accidents-vs-incidents>
- Reason, J. (2008). *Managing the risk of organizational accidents*. Burlington, VT: Ashgate Publishing Limited.
- U.S. Printing Office, (2014). *Title 49 subtitle b chapter viii part 830 (Part 830)*. Retrieved from website: <http://www.ecfr.gov/cgi-bin/text-idx?SID=0f3aacef807f1073f4b70afe5b4a4c22&node=sp49.7.830.b&rgn=div6>

Grundig, J. (2013, Aug 20). Understanding far part 135. Retrieved from
<http://www.sherpareport.com/aircraft/aircraft-overview/far-part-135.html>

APPENDICES

APPENDIX A

IRB APPROVAL FORM

Oklahoma State University Institutional Review Board
Request for Determination of Non-Research or Non-Human Subject

Federal regulations and OSU policy require IRB review of all research involving human subjects. Some categories of research are difficult to discern as to whether they qualify as human subject research. Therefore, the IRB has established policies and procedures to assist in this determination.

1. Principal Investigator Information

First Name: BRADLEY	Middle Initial: V	Last Name: KEITH
Department/Division: AVIATION AND SPACE SCIENCE		College: COLLEGE OF EDUCATION
Campus Address: N/A		Zip+4: N/A
Campus Phone: N/A	Fax:	Email: BRAD.KEITH@OKSTATE.EDU
Complete if PI does not have campus address:		
Address: 15212 S.E. 57th St.		City: CHOCTAW
State: OKLAHOMA	Zip: 73020	Phone: 405-584-9906

2. Faculty Advisor (complete if PI is a student, resident, or fellow) NA

Faculty Advisor's name: DR. STEVE MARKS	Title: Ed.D
Department/Division: AVIATION AND SPACE SCIENCE	College: COLLEGE OF EDUCATION
Campus Address: 300 CORDELL NORTH	Zip+4: 74078
Campus Phone: 405-744-8125	Fax: Email: STEVE.MARKS@OKSTATE.EDU

3. Study Information:

A. Title

QUANTITATIVE INQUIRY INTO
 FEDERAL AVIATION ADMINISTRATION
 FLIGHT INSPECTION SERVICES
 SAFETY SIGNIFIGANT EVENTS

B. Give a brief summary of the project. (See instructions for guidance)

This research presents a case study of the Safety Significant Events (SSE) over the 2009 through 2012 period of time for the Federal Aviation Administration, Flight Inspection Services Organization. A Safety Significant Event is an event that occurs in flight or on the ground, other than an aircraft accident or incident as defined in 49 CFR Part 830, which affects or could affect the safety of an FAA aircraft or aircrew member. In addition, any use of the abnormal or emergency checklist requires an SSE report (ASAP, 2013). The organization is headquartered in Oklahoma City, Oklahoma, with field offices housed in Atlanta, Georgia; Battle Creek, Michigan; Atlantic City, New Jersey; Sacramento, California; and Anchorage, Alaska. The purpose of the research was to objectively examine the Safety Significant Events that occurred and to quantitatively review those findings to improve public safety. The purpose of this quantitative study is to conduct detailed analysis of de-identified Safety Significant Events in the governmental sector to determine safety trends and latent conditions that occur in flight or on the ground that affects or could affect the safety

Oklahoma State University Institutional Review Board
Request for Determination of Non-Research or Non-Human Subject

of an FAA aircraft or aircrew member. The study should not only benefit the organization by providing a chronological perspective from which future decisions may be enriched, but should also serve as a resource to other CFR Part 135 Operators, both public and private to improve aviation safety.

- C. Describe the subject population/type of data/specimens to be studied. (See instructions for guidance)

All 185 Safety Significant Events that occurred during 2009 through 2012 period of time for the Federal Aviation Administration, Flight Inspection Services Organization

4. Determination of "Research".

45 CFR 46.102(d): *Research* means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy whether or not they are conducted or supported under a program which is considered research for other purposes.

One of the following must be "no" to qualify as "non-research":

- A. Will the data/specimen(s) be obtained in a systematic manner?
 No Yes
- B. Will the intent of the data/specimen collection be for the purpose of contributing to generalizable knowledge (the results (or conclusions) of the activity are intended to be extended beyond a single individual or an internal program, e.g., publications or presentations)?
 No Yes

5. Determination of "Human Subject".

45 CFR 46.102(f): *Human subject* means a living individual about whom an investigator (whether professional or student) conducting research obtains: (1) data through intervention or interaction with the individual or (2) identifiable private information. Intervention includes both physical procedures by which data are gathered (for example venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes. Interaction includes communication or interpersonal contact between investigator and subject. Private information includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record). Private information must be individually identifiable (i.e., the identity of the subject is or may be ascertained by the investigator or associated with the information) in order for obtaining the information to constitute research involving human subjects.

- A. Does the research involve obtaining information about living individuals?
 No Yes
**If no, then research does not involve human subjects, no other information is required.
If yes, proceed to the following questions.**

All of the following must be "no" to qualify as "non-human subject":

- B. Does the study involve intervention or interaction with a "human subject"?
 No Yes

Oklahoma State University Institutional Review Board
Request for Determination of Non-Research or Non-Human Subject

- C. Does the study involve access to identifiable private information?
 No Yes
- D. Are data/specimens received by the investigator with identifiable private information?
 No Yes
- E. Are the data/specimen(s) coded such that a link exists that could allow the data/specimen(s) to be re-identified?
 No Yes
If "Yes," is there a written agreement that prohibits the PI and his/her staff access to the link?
 No Yes

6. Signatures

Signature of PI *R. A. V. Kelly* Date 8/28/13
Signature of Faculty Advisor *John Mark* Date 8-28-13
(If PI is a student)

Based on the information provided, the OSU-Stillwater IRB has determined that this project **does not** qualify as human subject research as defined in 45 CFR 46.102(d) and (f) and **is not subject to oversight by the OSU IRB.**

Based on the information provided, the OSU-Stillwater IRB has determined that this research **does** qualify as human subject research and **submission of an application for review by the IRB is required.**

Sheila M. Kennison Date 8-29-13
Dr. Sheila Kennison, IRB Chair

APPENDIX B
FREEDOM OF INFORMATION ACT REQUEST

FOIA Form - Your request has been submitted

Page 1 of 2



FOIA Form

Your request has been submitted

Your FOIA request has been submitted. Save or print this page for your records.

BRADLEY KEITH

*OKLAHOMA STATE UNIVERSITY, DOCTOR OF EDUCATION IN AVIATION AND SPACE SCIENCE
11536 SHEFFIELD ST.*

MIDWEST CITY, OK 73130

February 20, 2013

Federal Aviation Administration

Central Service Area, Air Traffic Organization FOIA Coordinator, AJO2C5

2601 Meacham Boulevard

Ft. Worth, TX 76193

FOIA Coordinator:

This is a request under the Freedom of Information Act. I request that a copy of the following documents (or documents containing the following information) be provided to me:

I am writing to request the 2009-2012 DE-IDENTIFIED Safety Significant Events records from the Federal Aviation Administration, Technical Operations, Flight Inspection Services, Safety Significant Events database at <http://avn-safety.wbat.org/>. I am requesting that the reports are DE-IDENTIFIED to remove Employee User Name, First Name, and Last Name. Aircraft Configuration Nickname, Tail Number and Flight Crew Employee Information Primary Duties during Time of Event. The Safety Significant Events (SSE) that I am requesting are in response to an event that occurs in flight or on the ground, other than an aircraft accident or incident as defined in 49 CFR Part 830, which affects or could affect the safety of an FAA aircraft or aircrew member. In addition, any use of the abnormal or emergency checklist requires an SSE report. I kindly request that you provide this information and these documents in electronic format to the email address brad.keith@okstate.edu. If no electronic copy of the document is available I request a copy be mailed to: Brad Keith 11536 Sheffield St. Midwest City, OK, 73130 Request for a Fee Waiver: I request a fee waiver. I am intending to use the information provided in response to this request for the public good through the analysis of a Part 135 Operators Safety Significant Events in relation to the current safety risk mitigations that are currently being promoted within the industry. After this information is analyzed it would be presented to the Oklahoma State University, Doctor of Education in Aviation and Space Science Department Committee in the Dissertation format for its Defense and made available for public study. Willingness to pay applicable cost: For the aforementioned reasons, I do not believe fees are appropriately assessed for the purpose of this request since this information will be made available for public education. I will, however pay cost up to \$100 for the materials under protest. Thank you for your consideration of this request. Bradley V. Keith

http://www.faa.gov/foia/email_foia/submitted/

2/20/2013

FOIA Form - Your request has been submitted

Page 2 of 2

In order to determine my status to assess fees, you should know that my fee category is:

affiliated with an educational or noncommercial scientific institution, and this request is made for a scholarly purpose. Students are not included in this category.

The maximum dollar amount I am willing to pay for this request is \$100. Please notify me if the fees will exceed \$25.00 or the maximum dollar amount I entered.

Thank you for your consideration of this request.

Sincerely,

BRADLEY KEITH
ACADEMICALLY - DOCTORAL CANDIDATE...PROFESSIONALLY - MANAGEMENT AND PROGRAM
ANALYST FOR THE FEDERAL AVIATION ADMINISTRATION, TECH OPS, FLIGHT INSPECTION
SERVICES, AJW-33

Phone: 405-584-9906

BRAD.KEITH@OKSTATE.EDU

Page Last Modified: 10/12/12 09:24 EDT

This page can be viewed online at: http://www.faa.gov/foia/email_foia/submitted/

APPENDIX C

FREEDOM OF INFORMATION ACT ACCEPTANCE



U.S. Department
of Transportation

FOIA Program Management Branch

800 Independence Avenue SW
Washington, DC 20591

Federal Aviation
Administration

February 26, 2013

Mr. Bradley Keith
11536 Sheffield Street
Midwest City, OK 73130

Freedom of Information Act (FOIA) Request 2013-2907

Dear Mr. Keith:

This is to acknowledge receipt today of a referral from the Central Service Area of your February 20 FOIA request for a copy of the 2009-2012 de-identified safety significant events records from the Safety Significant Events database.

Your request has been assigned for action to the following Federal Aviation Administration office:

Air Traffic Organization
800 Independence Avenue SW
Washington, DC 20591

Contact: Dean Torgerson
FOIA Coordinator
Telephone: 202-493-4119

If you wish to inquire as to the status of your request, please contact the assigned FOIA coordinator. Please refer to the above-referenced number on all future correspondence regarding this request.

Your request for a fee waiver is denied as you do not meet the requirements as outlined in Departmental Regulations, 49 CFR Section 7.44(f), as follows: Section (f)(3) - the disclosure of the requested information will not contribute to the understanding of the public at large, as opposed to the individual understanding of the requester or a narrow segment of interested persons.

As an "all other" requester, fees for your request will be calculated as follows: (1) reasonable standard charges for search time (first 2 hours free); (2) reasonable standard charges for duplication (no charge for the first 100 pages); (3) other forms of duplication charged at actual cost; and (4) no charge for review time.

The undersigned is responsible for this fee waiver denial. You may request reconsideration of this determination by writing to the Assistant Administrator for Finance and Management (AFN-140), Federal Aviation Administration, 800 Independence Avenue SW., Washington, DC 20591. Your request must be made in writing within 30 days from the date of receipt of this letter and must include all information and arguments relied upon. Your letter must also state that it is an appeal from the above-described fee waiver denial and include your assigned FOIA control number. The envelope containing the appeal should be marked "FOIA Appeal."

Sincerely,

Douglas C. Taylor, Ph.D.
Manager, FOIA Program
Management Branch

APPENDIX D
FAA FIS SSE DATASET

Deidentified Crewmembers Analyst SSE Report 664

Overview:

Processing:

Status: Closed

ID: 664

Date/Time When Event Occurred: Tue, 10 Dec 2013 17:30 Z

Local Time When Event Occurred: 11:30

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 10 Dec 2013 21:25 Z

Submission Date/Time: Tue, 10 Dec 2013 21:25 Z

Source: Web Submission

Form Name: submission-form

Debrief Narrative: 12/10/13 IAW T.I. 4105.2 TASK 05-51-01-210-801 HARD OVERWEIGHT LANDING INSP CHECK, DOWNLOADED FOQA DATA SHOWED @ 2 SECOND BEFORE TOUCH DOWN SINK RATE WAS 120FPM AND AT TOUCHDOWN 60FPM AND WEIGHT WAS WITHIN OVERWEIGHT LANDING ACCEPTABLE RANGE OF 44000LBS IAW FIG 601. NO ACTION REQUIRED AT THIS TIME. INSPECTED AIRCRAFT IAW CARD GEN-4331 SMOKE AND FUMES IN AIRCRAFT INSP AND FOUND SMELL WAS FROM COMPRESSOR WASH FLUID THAT HAD SOAKED THE WATER SEPERATOR COALESCER BAGS. REMOVED AND REPLACED LEFT AND RIGHT ACM COALESCER BAGS IAW T.I. 4105.2 CHAP 21-51-13-400-801 OPS AND LEAK CHECKED GOOD. OPERATED BOTH ENGINES TO 85% N2 FOR SEVERAL MINUTES WITH NO SMELL NOTICED. VENTED AIRCRAFT CABIN OVERNIGHT WITH FRESH AIR.

Exclude this report from Scoreboard: No

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 124.2

Name of ATC Facility: OKC Approach

Aircraft Configuration:

Nickname: N90

Tail Number: N90

Aircraft Type: CL-605

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Airport: OKC/KOKC - 17R/35L

Narrative:

After an uneventful takeoff, conducted by the SIC from KOKC, at approx. 1130 lcl, and during the climb out from KOKC, the Mission Specialist advised us that he could smell a strong smell of burning coming from the cabin area. Shortly after we were notified by the MS, both pilots could also smell something that we believed resembled plastic or rubber, similar to an electrical type smell, At this time, the PIC advised ATC that we requested a level off at 7000 feet, and an immediate return to KOKC. The PIC further advised ATC that he was not declaring an emergency, but requested an expedited return to the airport.

During the subsequent expedited descent, the smell began to dissipate, but did not extinguish completely.

An uneventful overweight landing and touchdown was made and the aircraft was taxied to the ramp and turned over to maintenance for corrective action.

Phase of Flight:

Flight Phase at Start of Event: Climb

Cause

Narrative:

The cause of the electrical burning type smell has not been determined as of this writing, but may be associated either with an electrical component malfunction or foreign matter in the air conditioning system.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction
Flight Crew:
Declared Emergency with ATC: No
Contacted ATC: Yes
Flight Status after Event:
Precautionary Landing: Yes
Suggestions
Narrative:
None

Deidentified Crewmembers Analyst SSE Report 663

Overview:
Processing:
Status: Closed
ID: 663
Date/Time When Event Occurred: Wed, 04 Dec 2013 21:00 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Thu, 05 Dec 2013 15:07 Z
Submission Date/Time: Thu, 05 Dec 2013 15:09 Z
Source: Paper Submission
Form Name: submission-form
Debrief Narrative: 12/7/13 Removed and replaced NCU - Loaded program and database - ran AFIS system 2.5 hours in different modes and w/AC and w/o AC - no defents noted. Ref AFIS EO 06-28-16.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: N/A
Aircraft Configuration:
Nickname: N70
Tail Number: N70
Aircraft Type: BE-300
Geographic Location:
Airport: BNA/KBNA
Narrative:
N70 AFIS locked-up during Sortie#1 run-up/system check and could not be corrected. Aircraft returned to KFTY on NEF for maintenance and returned to service. During FI of KBNA ILS 2L, AFIS TEMP Monitor indicated Airflow Too Low alert after two (2) hours of flight/operation. Right AFIS sliding screen froze in flight with a complete NCU lock-up and could not be reset in flight. After landing at KBNA in an attempt to execute a power-down restart of AFIS, an electrical burn smell was noticed in the cabin. When Mission Power was removed, electrical burn smell disappeared. FI equipment [AFIS] Mission Power remained off and aircraft moved to FBO without further incident. No emergency declared and Emergency Checklist not initiated/required. N70 down pending FICO and ATL Maintenance checks/servicing.
Cause
Narrative:
-
Detection
Reaction
Suggestions

Deidentified Crewmembers Analyst SSE Report 662

Overview:

Processing:

Status: Closed

ID: 662

Date/Time When Event Occurred: Tue, 26 Nov 2013 16:06 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 26 Nov 2013 22:30 Z

Submission Date/Time: Wed, 27 Nov 2013 13:43 Z

Source: Paper Submission

Form Name: submission-form

Debrief Narrative: 12/2/13 REMOVED, REPLACED AND RIGGED NLG UPLOCK SWITCH, OPS CHECKED GOOD. ADJUSTED AND RIGGED L/H MLG UPLOCK SWITCH, OPS CHECKED GOOD. RIGGED ALL MLG DOORS, OPS CHECKED GOOD. CYCLED GEAR NUMEROUS TIMES, NO DEFECTS NOTED. WORK DONE IAW TI 4128.2, CHAPTER 32-60, 32-30.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: N/A

Aircraft Configuration:

Nickname: N76

Tail Number: N76

Aircraft Type: BE-300

Geographic Location:

Airport: KMIC - 14L/32R

Narrative:

During MIC 14L PROC/G inspection, gear handle light illuminated and continued to flash after retraction. Had MS get MSP ATIS. Pilot Flying (SIC) handled communications while Pilot Not Flying (PIC) reviewed landing with unsafe gear indication checklist and briefed landing. PNF (PIC) resumed communications; PF (SIC) lowered gear; 3 green, no red. Landed without incident at MSP. Crash Fire Rescue was on standby for landing. Aircraft written up and turned over to maintenance.

Cause

Narrative:

-

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 661

Overview:

Processing:

Status: Closed

ID: 661

Date/Time When Event Occurred: Mon, 25 Nov 2013 23:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 26 Nov 2013 00:56 Z

Submission Date/Time: Tue, 26 Nov 2013 00:58 Z

Source: Web Submission

Form Name: submission-form

Debrief Narrative: 11/29/13 Removed and replaced stall protection computer, ops checkout ok IAW 4102.2 task 27-35-01-710-801 and 27-35-01-710-802

Event: 1

Baseline Risk Assessment

Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: N/A
Aircraft Configuration:
Nickname: N88
Tail Number: N88
Aircraft Type: CL-604
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Geographic Location:
Airport: ANC/PANC
Narrative:
Approximately 15 min prior to landing, during our descent the STALL FAIL CAS message presented. The crew performed the appropriate QRH checklist and landed uneventfully.
Phase of Flight:
Flight Phase at Start of Event: Approach
Cause
Narrative:
UNKNOWN
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Operated in Degraded Conditions: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 660

Overview:
Processing:
Status: Closed
ID: 660
Date/Time When Event Occurred: Wed, 13 Nov 2013 16:00 Z
Local Time When Event Occurred: 10:00
Viewer Accessible: Yes
Initial Notification Date/Time: Wed, 13 Nov 2013 18:46 Z
Submission Date/Time: Wed, 13 Nov 2013 19:09 Z
Source: Web Submission
Form Name: submission-form
Debrief Narrative: 11/13/13 REMOVED AND REPLACED LH ENGINE GENERATOR AND GCU IAW TI 4107.2 CHAPT 24-30-01 AND 24-30-03 OP CHECKED IAW CHAPT 24-30-00 CHECKED SATISFACTORY

11/26/13 Aircraft continued to have LH gen problems see ILM entries:

11/14/13, PERFORMED GENERATOR CONTROL UNIT ADJUSTMENT AND TEST ON LH AND RH GCUs. ADJUSTED RH GCU -.3 VOLTS BOTH GCUs MATCHED AT 28.5 VDC AT 60% N2 TESTED SATISFACTORY IAW TI 4107.2 CHAPT 24-30-00

11/26/13 PERFORMED GENERATOR CONTROL UNIT ADJUSTMENT AND TEST. PARALLELED LH AND RH GCUs READING 28.51 VDC AT 60% N2 AND PERFORMED DC GENERATION SYSTEM INSPECTION/CHECK. SYSTEM CHECKED SATISFACTORY IAW TI 4107.2 CHAPT 24-30-00

Event: 1

Baseline Risk Assessment

Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: N/A
Aircraft Configuration:
Nickname: N54
Tail Number: N54
Aircraft Type: LR-60
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Narrative:
While enroute from Port Lavaca, TX (KPKV) to Edinburg, TX (KEBG) the L GEN annunciator illuminated. Referenced the abnormal checkist, reset the generator, and it remained on line for 15 minutes and then failed again. Did not attempt to reset the generator a second time. Abnormality occurred in cruise flight on an IFR flight plan in day VMC conditions. Crew coordinated with FICO via AIRINC and the decision was made to return to KOKC. Valley Approach was notified of the situation and provided an IFR clearance to KOKC. The crew did not declare an emergency.
Phase of Flight:
Flight Phase at Start of Event: Cruise
Cause
Narrative:
Unknown. OKC aircraft maintenance is troubleshooting the discrepancy.
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Contacted ATC: Yes
Contacted Company: Yes
Operated in Degraded Conditions: Yes
Flight Status after Event:
Diversion: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 659

Overview:
Other Employees:
Employee Duty: Pilot Flying
First Name: Brent
Last Name: Booker
Processing:
Status: Closed
ID: 659
Date/Time When Event Occurred: Tue, 12 Nov 2013 18:18 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Tue, 12 Nov 2013 21:27 Z
Submission Date/Time: Tue, 12 Nov 2013 21:28 Z
Source: Web Submission
Form Name: submission-form
Debrief Narrative: 11/12/13 (MLG door actuators were disconnected during a recent A check) CONNECTED RT AND LT MLG INBD DOOR ACTUATORS TO DOORS PER TI 4107.2 CH 32-31-02. INSPECTED DOORS, ACTUATORS AND SURROUNDING AREA FOR DAMAGE. NO DAMAGE NOTED. EXTENDED AND RETRACTED LANDING GEAR SEVERAL TIMES. SYSTEM CK'D NORMAL. AMEG aslo initiated a Human Factors Investigation number 14-001. This resulted in an organization wide review of the need to document all maintenance actions and a revision to the Post -Check workcard to visually verify the MLG door actuators are connected.

Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N58
Tail Number: N58
Aircraft Type: LR-60
Speed IAS (Knots): 180
Aircraft System/Equipment Malfunction:
Equipment Malfunction: Landing Gear
Flight Crew Employee Information:
Duty Off Time: Tue, 12 Nov 2013 21:00 Z
Duty On Time: Tue, 12 Nov 2013 13:30 Z
Primary Duties During Time of Event: Pilot Flying
Flight Information:
Departure Airport, Runway and Gate: OKC/KOKC
Flight Number: FLC58
Revenue Flight: Part 135
Time of Day: Daylight
Non-Revenue Flight: Normal Operations
Scheduled Arrival Airport, Runway and Gate: SDF/KSDF
Landing Airport, Runway and Gate: OKC/KOKC
Filed Altitude (MSL): 40
Geographic Location:
Airport: OKC/KOKC
Narrative:
After takeoff, PIC directed gear up. SIC raised gear, however the main gear UNSAFE lights remained illuminated. PIC leveled off at 4,000 MSL, and requested a holding pattern south of KOKC for troubleshooting.
Phase of Flight:
Flight Phase at Start of Event: Takeoff
Weather:
Meteorological Conditions: VMC
Weather Description: CAVU
Cause
Narrative:
Upon post-flight inspection, the main landing gear inboard doors were extended with no actuator attached to either door.
Detection
How Event Detected:
Flight Crew: Yes
When Event Detected:
In-Flight: Yes
Reaction
Action Taken:
Accepted: Yes
Flight Crew:
Changed Configuration-Flaps/Trim: Yes
Flight Status after Event:
Air Turnback: Yes
Narrative:
During holding, the PIC directed flaps 20, gear down. All three gear down "green" lights illuminated, while both main gear UNSAFE lights remained illuminated. Crew had to hold for 2.3 hrs to burn down to landing weight before returning to KOKC.
Suggestions
Narrative:

Maintenance had performed maintenance on N58 prior to this flight. However, the mechanic failed to reconnect the gear door actuators. Additionally, the QC inspector did not verify the actuators had been reconnected. Recommend QC perform thorough inspection prior to signing off work performed.

Deidentified Crewmembers Analyst SSE Report 657

Overview:

Processing:

Status: Closed

ID: 657

Date/Time When Event Occurred: Tue, 05 Nov 2013 23:30 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 06 Nov 2013 18:42 Z

Submission Date/Time: Wed, 06 Nov 2013 18:47 Z

Source: Paper Submission

Form Name: submission-form

Debrief Narrative: 11/8/13 Removed copilots windscreen, replaced with new windscreen ref: TI 4102.2 Chap 56-11-01-400-801, leak check task 56-10-00-790-801 & anti ice check 30-41-00-710-801. all checks good

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: N/A

Aircraft Configuration:

Nickname: N88

Tail Number: N88

Aircraft Type: CL-604

Narrative:

300 miles southwest of ANC. Outer ply of copilot windshield cracked at FL350. Performed "Windshield Outer Face Ply Failure" checklist as described in QRH. On descent approximately 6000 ft and 20 miles from airport, majority of outer ply departed aircraft (over water and not heavily navigated).

Cause

Narrative:

-

Detection

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 658

Overview:

Processing:

Status: Closed

ID: 658

Date/Time When Event Occurred: Mon, 04 Nov 2013 06:15 Z

Local Time When Event Occurred: 01:15

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 07 Nov 2013 23:24 Z

Submission Date/Time: Thu, 07 Nov 2013 23:41 Z

Source: Web Submission

Form Name: submission-form

Debrief Narrative: 11/3/13 Deferred with DMI Number: 34

11/3/13 Dent patched at KBOS

11/7/13 Patch painted at ACY

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: N/A

Aircraft Configuration:

Nickname: N78

Tail Number: N78

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Airport: BOS/KBOS - 15R/33L

Narrative:

KBOS, left downwind RWY 33L during night flight inspection. While entering a left downwind to RWY 33L (After completion of Low approach RWY 22L, gear and flaps down) a thump was felt on and around the nosewheel landing gear area, resembling a bird strike. Landing continued. During Postflight, bird guts / feathers were observed on the right wings leading edge, between right engine cowling and fuselage. Metal cover where fuselage and leading edge meet had a 6 in dent in diameter.

Phase of Flight:

Flight Phase at Start of Event: Landing

Cause

Narrative:

Bird on flight path.

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

PostFlight: Yes

Reaction

Flight Status after Event:

Flight Delay: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 656

Overview:

Processing:

Status: Closed

ID: 656

Date/Time When Event Occurred: Thu, 31 Oct 2013 09:30 Z

Local Time When Event Occurred: 17:30

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 01 Nov 2013 16:52 Z

Submission Date/Time: Fri, 01 Nov 2013 17:08 Z

Source: Web Submission

Form Name: submission-form

Debrief Narrative: As of 11/26/13 there is no corresponding log book/ILM entry

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: N/A

Aircraft Configuration:

Nickname: N70

Tail Number: N70

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

KGSO Greensboro/Piedmont Triad Airport. On an ILS 3 approach less than one mile from the threshold a flock of small birds crossed perpendicular to final course. The flock dispersed in all directions, it appeared we missed them. The small birds apparently glanced off the right side of the fuselage, leaving a small amount of SNARGE, no feathers. No damage noted to the aircraft on post flight. SNARGE sample sent to the Smithsonian.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Bird occupying my airspace.

Detection

How Event Detected:

Flight Crew: Yes

Maintenance Personnel: Yes

When Event Detected:

PostFlight: Yes

Reaction

Flight Crew:

Returned to Assigned Course/Heading: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Narrative:

N/A

Deidentified Crewmembers Analyst SSE Report 655

Overview:

Processing:

Status: Closed

ID: 655

Date/Time When Event Occurred: Tue, 22 Oct 2013 06:47 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 23 Oct 2013 00:00 Z

Submission Date/Time: Wed, 23 Oct 2013 13:27 Z

Source: Paper Submission

Form Name: submission-form

Debrief Narrative: As of 11/26/13 there is no corresponding log book/ILM entry

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: N/A

Aircraft Configuration:

Nickname: N87

Tail Number: N87

Aircraft Type: CL-601

Narrative:

While maneuvering for an ILS-2 struck a bird. Pictures taken and sent into FICO MX.

*Airport ID: UCFM
Rwy: 26
1500' AGL
220 KIAS
Sky Clear
Struck nose of aircraft
Medium size bird
Not warned of birds
Snarge mailed to Smithsonian
Cause
Narrative:
-
Detection
Reaction
Suggestions*

Deidentified Crewmembers Analyst SSE Report 653

*Overview:
Processing:
Status: Closed
ID: 653
Date/Time When Event Occurred: Tue, 08 Oct 2013 18:00 Z
Local Time When Event Occurred: 14:00
Viewer Accessible: Yes
Initial Notification Date/Time: Wed, 09 Oct 2013 18:43 Z
Submission Date/Time: Wed, 09 Oct 2013 18:43 Z
Source: Web Submission
Form Name: submission-form
Debrief Narrative: 10/14/13 Found Tailcone Bleed Air Overheat Sensing Element improperly routed. Routed Bleed Air Overheat Sensing Element IAW TI 4107.2-1 CH 26-13-01 pg210. Performed engine run for 8 minutes at MCR with no defects noted. Performed operational test's IAW TI 4107.2-1 CH 26-13-01 pg209.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: N/A
Aircraft Configuration:
Nickname: N55
Tail Number: N55
Aircraft Type: LR-60
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Geographic Location:
Navigational Aid/VORTAC: BROOKE (BRV) - 140/10
Narrative:
Shortly after a climb from from 9000' to 15000' MSL the "BLEED AIR L" and "BLEED AIR R" warning lights illuminated. The emergency checklist page 7, TAB 4, "BLEED AIR Light" was accomplished. With the R bleed air switch in the off position, both lights went out. The right bleed air switch was left off IAW the checklist and we landed KBWI without incident. After landing the cabin air switch was turned off IAW with the normal after landing checklist at which time both BLEED AIR warning lights illuminated again. After approximaetly 15 seconds and with no changes to bleed air or cabin air switch positions the lights went out.
Phase of Flight:
Flight Phase at Start of Event: Cruise
Cause
Narrative:*

Maintenance is working the issue.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 651

Overview:

Processing:

Status: Closed

ID: 651

Date/Time When Event Occurred: Tue, 10 Sep 2013 15:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 10 Sep 2013 18:41 Z

Submission Date/Time: Tue, 10 Sep 2013 18:45 Z

Source: Paper Submission

Form Name: submission-form

Debrief Narrative: 9/10/13 Removed and Inspected J3 & J4 cannon plugs on IAPS cage. Ops check of system shows normal operation.

REF TI4128.5-2 ATA 22-10.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: N/A

Aircraft Configuration:

Nickname: N70

Tail Number: N70

Aircraft Type: BE-300

Geographic Location:

Airport: TYS/KTYS

Narrative:

Aircraft departed Fulton County (KFTY) on a routine flight inspection mission at McGee-Tyson Airport (KTYS). Approximately 2.5 hours into flight the Rudder Boost light illuminated with no other indication of a malfunction. Crew referenced checklist for Rudder Boost light and performed all steps. Light remained illuminated and crew returned to KFTY.

Cause

Narrative:

-

Detection

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 650

Overview:

Processing:

Status: Closed

ID: 650

Date/Time When Event Occurred: Wed, 04 Sep 2013 22:05 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 05 Sep 2013 12:58 Z

Submission Date/Time: Thu, 05 Sep 2013 13:04 Z

Source: Paper Submission

Form Name: submission-form

Debrief Narrative: Reloaded Data in FMC's, in order Performance Data, VSpeed Data, and Nav Database 1309B, system ops check good with No lockups on ground. IAW 34-61-00-710-801

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: N/A

Aircraft Configuration:

Nickname: N88

Tail Number: N88

Aircraft Type: CL-604

Geographic Location:

Navigational Aid/VORTAC: KENAI (ENA) - 50/12

Narrative:

While turning to intercept the Kenai ILS 19R 10NM ILS-1, all three FMSs locked up rendering the FMSs unusable. Loss of all three FMSs also rendered the autothrottles and takeoff/landing data information unusable. No checklists are available for this type of malfunction. Advised ATC that the flight could no longer operate as a /R or /Q and could be handled as a /A.

Manual calculation of approach and landing data was accomplished. A normal ILS approach and landing were accomplished with no further incident.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

-

Detection

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 649

Overview:

Processing:

Status: Closed

ID: 649

Date/Time When Event Occurred: Tue, 03 Sep 2013 18:30 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 03 Sep 2013 20:03 Z

Submission Date/Time: Tue, 03 Sep 2013 20:09 Z

Source: Paper Submission

Form Name: submission-form

Debrief Narrative: Ran no. 1 inverter for several hours; did not lose inverter. Suspect weak relay contacts. Remove LH inboard leading edge. Removed and replaced no. 1 inverter power relay. Ran engines to ops check system. Ops check surface deice for proper inflation.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: N/A
Aircraft Configuration:
Nickname: N79
Tail Number: N79
Aircraft Type: BE-300
Geographic Location:
Navigational Aid/VORTAC: VULCAN (VUZ)
Narrative:
During cruise flight at FL200, Master Warning Flasher illuminated followed by Inverter Master Warning Annunciator. Other [#2] inverter selected by Pilot Flying; Emergency Checklist consulted and memory items verified. Return to KFTY requested from ATC. Aircraft landed at KFTY without further incident. No emergency declared.
Phase of Flight:
Flight Phase at Start of Event: Cruise
Cause
Narrative:
-
Detection
When Event Detected:
In-Flight: Yes
Reaction
Flight Status after Event:
Precautionary Landing: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 648

Overview:
Processing:
Status: Closed
ID: 648
Date/Time When Event Occurred: Tue, 27 Aug 2013 15:05 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Tue, 27 Aug 2013 19:51 Z
Submission Date/Time: Tue, 27 Aug 2013 19:59 Z
Source: Paper Submission
Form Name: submission-form
Debrief Narrative: Removed and replaced AC Power Monitor unit. Ops check on Inverter 1 and 2. Ops check good.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: N/A
Aircraft Configuration:
Nickname: N79
Tail Number: N79
Aircraft Type: BE-300
Geographic Location:
Navigational Aid/VORTAC: ALMA (AMN)
Narrative:
During cruise flight at FL230, Master Warning Flasher illuminated followed by the Inverter Master Warning Annunciator. Other [#2] inverter selected by Pilot Flying; Emergency Checklist consulted and memory items verified. Return to KFTY requested from ATC. Aircraft landed at KFTY without further incident.
[No emergency declared.]
Phase of Flight:
Flight Phase at Start of Event: Cruise

Cause

Narrative:

-

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

Reaction

Flight Status after Event:

Precautionary Landing: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 647

Overview:

Processing:

Status: Closed

ID: 647

Date/Time When Event Occurred: Fri, 16 Aug 2013 16:40 Z

Local Time When Event Occurred: 12:40

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 16 Aug 2013 18:10 Z

Submission Date/Time: Fri, 16 Aug 2013 18:10 Z

Source: Web Submission

Form Name: submission-form

Debrief Narrative: FOUND B NUT LEAKING AT RIGHT MAIN GEAR LOWER HYD LINE. TIGHTENED B NUT, SERVICED AND BLED SYSTEM. TAXI OPS CHECK LEAK CHECK GOOD.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 124.6

Name of ATC Facility: KACY

Aircraft Configuration:

Nickname: N78

Tail Number: N78

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Narrative:

While in cruise flight, PIC notice right brake pedal (right seat) had no resistance. Requested SIC (flying pilot) to verify his brakes on the left seat. SIC advised of same problem noted. Diverted to home base and uneventful landing complete. Exited the RWY and shutdown. FAA maintenance towed aircraft back to hangar.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Right brake system failure.

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Declared Emergency with ATC: Yes

Contacted ATC: Yes
Flight Status after Event:
Precautionary Landing: Yes
Diversion-Filed Alternate: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 646

Overview:

Processing:

Status: Closed

ID: 646

Date/Time When Event Occurred: Thu, 15 Aug 2013 20:39 Z

Local Time When Event Occurred: 16:39

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 16 Aug 2013 13:59 Z

Submission Date/Time: Fri, 16 Aug 2013 13:59 Z

Source: Web Submission

Form Name: submission-form

Debrief Narrative: After close visual insp, found no damage. Work performed by Rick Denson, KCLT, 8/15/2013, RU3A249N.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: N/A

Aircraft Configuration:

Nickname: N85

Tail Number: N85

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Geographic Location:

Airport: CLT/KCLT - WILSON

Narrative:

After block in at KCLT, aircraft was struck on left wing leading edge and forward portion of the middle flap fairing underneath wing by an unoccupied moving vehicle (Ford Ranger truck). The SIC, MS, and MX crew chief were onboard the aircraft and did not see the incident. The PIC was on the ramp and witnessed the impact.

Phase of Flight:

Flight Phase at Start of Event: Parked

Cause

Narrative:

Aircraft was parked approximately 90 yards from the FBO front door. The FBO was located off the aircraft's right wing. The vehicle was parked in front of the FBO, facing opposite direction of the aircraft. It was unattended with the engine idling. Surveillance video shows the vehicle moving in reverse over a circuitous route for over 200 yards between rows of aircraft and fuel trucks before striking N85 on the left wing. PIC observed approximately last 50 feet of travel and estimated vehicle speed at 5 mph at time of impact.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

Ramp: Yes

Reaction

Flight Crew:

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Flight Status after Event:

Flight Delay: Yes

Suggestions

Narrative:

FBO needs to set brakes and chocks on flight line vehicles . Engines of unattended vehicles need to be shut down.

Deidentified Crewmembers Analyst SSE Report 644

Overview:

Other Employees:

Employee Duty: Pilot

First Name: Jorge

Middle Initial: A

Last Name: Malcun

Suffix: Mr.

Processing:

Status: Closed

ID: 644

Aware Date/Time: Mon, 12 Aug 2013 13:30 Z

Date/Time When Event Occurred: Mon, 12 Aug 2013 13:30 Z

Local Time When Event Occurred: 09:30

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 14 Aug 2013 14:19 Z

Submission Date/Time: Wed, 14 Aug 2013 14:19 Z

End of Trip Date/Time: Mon, 12 Aug 2013 14:00 Z

Source: Web Submission

Form Name: submission-form

Debrief Narrative: REMOVED AND REPLACED ALL 4 BRAKE ASSY'S IAW TI4128.2 CH32. REMOVED AND REPLACED PARKING BRAKE VALVE IAW TI4128.2 CH32. BLED SYSTEM OPS CHECK GOOD.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 121.9

Name of ATC Facility: ACY

Aircraft Configuration:

Nickname: N78

Tail Number: N78

Aircraft Type: BE-300

Flight Crew Employee Information:

Duty Off Time: Mon, 12 Aug 2013 20:00 Z

Duty On Time: Mon, 12 Aug 2013 11:30 Z

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Flight Information:

Departure Airport, Runway and Gate: ACY/KACY - 13/31

Scheduled Arrival Airport, Runway and Gate: PHF/KPHF - 07/25

Landing Airport, Runway and Gate: PHF/KPHF - 07/25

Geographic Location:

Airport: ACY/KACY - 13/31

Narrative:

While taxiing for departure at KACY ramp, crew notice engine power required to taxi was higher than normal and suspected "brakes were dragging". Crew reset and pumped brakes with no positive results. Aircraft maintenance boarded aircraft, upon taxiing around ramp, brakes appeared to have improved. But, crew elected to have them inspected.

Phase of Flight:

Flight Phase at Start of Event: Taxi-Out

Weather:

Meteorological Conditions: VMC

Cause

Narrative:

Upon inspection, maintenance determined that "both inboard tires" on main landing gear would not turn freely, as if the brakes were set "ON". Maintenance determined that parking brake valve was defective and requires replacement. Main landing gear "Outer wheels" turned freely.

Detection

Reaction

Action Taken:

Notified Supervisor: Yes

Narrative:

Upon inspection, maintenance determined that "both inboard tires" on main landing gear would not turn freely, as if the brakes were set "ON". Maintenance determined that parking brake valve was defective and requires replacement. Main landing gear "Outer wheels" turned freely.

Suggestions

Deidentified Crewmembers Analyst SSE Report 643

Overview:

Processing:

Status: Closed

ID: 643

Date/Time When Event Occurred: Wed, 07 Aug 2013 15:30 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 12 Aug 2013 19:02 Z

Submission Date/Time: Wed, 14 Aug 2013 12:50 Z

Source: Web Submission

Form Name: submission-form

Debrief Narrative: Installed new ari conditioning compressor drive oil seal carrier, ORing and garloc seal. Installed new oil filter and checked R6B Chip Detector. Serviced engine with Mobile Jet II Oil. Leak and ops check good IAW TI 4128.2 Chapter 21-50-00, 72-20-02, and 71-00-10. Scott Evaschuck, AP 2734393, Westcoast Aviation, SRQ.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: NA

Aircraft Configuration:

Nickname: N72

Tail Number: N72

Aircraft Type: BE-300

Geographic Location:

Airport: KVNC - 04/22

Narrative:

While commissioning PAPI's on RWY 23 the right engine oil pressure dropped to 84 PSI. Engine oil pressure gage was flashing (yellow). Reduced power and landed at near by KSRQ.

Phase of Flight:

Flight Phase at Start of Event: Holding

Cause

Narrative:

Airconditioning compressor accessory coupling (quill shaft) leaking oil.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes
Reaction
Flight Crew:
Contacted ATC: Yes
Flight Status after Event:
Flight Delay: Yes
Suggestions
Narrative:
NA.

Deidentified Crewmembers Analyst SSE Report 642

Overview:
Processing:
Status: Closed
ID: 642
Date/Time When Event Occurred: Fri, 02 Aug 2013 14:15 Z
Local Time When Event Occurred: 10:15
Viewer Accessible: Yes
Initial Notification Date/Time: Mon, 05 Aug 2013 17:18 Z
Submission Date/Time: Mon, 05 Aug 2013 17:24 Z
Source: Web Submission
Form Name: submission-form
Debrief Narrative: REMOVED AND REPLACED ELECTRONIC ENGINE CONTROL IAW TI 4107.72 CHAPTER 73-20-02. SYSTEM OPS CKS NORMAL.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: N/A
Aircraft Configuration:
Nickname: N54
Tail Number: N54
Aircraft Type: LR-60
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Geographic Location:
Airport: CRW/KCRW
Navigational Aid/VORTAC: CHARLESTON (HVQ)
Narrative:
During inspection of ZID (Indianapolis Center) ADS-B system, approaching HVQ from the East, VFR at 3,000 ft, the crew observed both the amber and white "R ENG CMPTR" annunciators simultaneously illuminated. The PF began climbing while the PNF referenced the Amber and White ENG CMPTR Light checklist. The PF made slow throttle movements and observed normal indications. The crew elected to abort the mission and return to KOKC, and kept the right engine computer in AUTO mode. The crew did not observe any additional abnormal engine indications, and the amber and white lights remained illuminated for the duration of the flight to KOKC. Crew landed uneventfully. After taxiing into parking and shutting down both engines, the crew showed the Maintenance Crew Chief the annunciators, permitting him to record the appropriate engine malfunction code(s) prior to powering down the aircraft electrical system. PIC recorded malfunction in aircraft logbook.
Phase of Flight:
Flight Phase at Start of Event: Cruise
Cause
Narrative:
The engines were in a steady power setting (approx 60% N1) when the lights illuminated. Unsure why the ENG CMPTR lights illuminated.
Detection

Aircraft Equipment:
Aircraft Warning/Message System: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Contacted Operations: Yes
Operated in Degraded Conditions: Yes
Flight Status after Event:
Diversion: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 640

Overview:
Processing:
Status: Closed
ID: 640
Date/Time When Event Occurred: Thu, 01 Aug 2013 17:00 Z
Local Time When Event Occurred: 12:00
Viewer Accessible: Yes
Initial Notification Date/Time: Fri, 02 Aug 2013 18:22 Z
Submission Date/Time: Fri, 02 Aug 2013 18:22 Z
Source: Web Submission
Form Name: submission-form
Debrief Narrative: 8/2/13 REMOVED AND REPLACED LEFT AP MODE SELECT PANEL AND C/W GOOD AP OPS CHECK
Notes: Repair entered in records 8/5/13
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: N/A
Aircraft Configuration:
Nickname: N76
Tail Number: N76
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Geographic Location:
Navigational Aid/VORTAC: BLOOMINGTON (BMI) - 70/27
Narrative:
AUTOPILOT STARTED UNCOMMANDED DESCENT, PILOT FLYING LEVELED OFF 300 FEET BELOW ALTITUDE THEN RETURNED TO ASSIGNED ALTITUDE.
Phase of Flight:
Flight Phase at Start of Event: Holding
Cause
Narrative:
AUTOPILOT STARTED UNCOMMANDED DESCENT.
Detection
How Event Detected:
Flight Crew: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:

Returned to Assigned Altitude: Yes
Flight Status after Event:
No Disruption: Yes
Suggestions
Narrative:
EVENT WRITTEN UP IN AIRCRAFT LOGBOOK.

Deidentified Crewmembers Analyst SSE Report 638

Overview:
Processing:
Status: Closed
ID: 638
Date/Time When Event Occurred: Tue, 30 Jul 2013 21:15 Z
Local Time When Event Occurred: 17:15
Viewer Accessible: Yes
Initial Notification Date/Time: Wed, 31 Jul 2013 15:00 Z
Submission Date/Time: Wed, 31 Jul 2013 15:00 Z
Source: Web Submission
Form Name: submission-form
Debrief Narrative: 7/31/13 Drained R/H engine sense line to FADAC + inspect engine IAW TI4109.2 ch 76 & 72. Engine run up all indications normal. Work performed by Mark Ingram RU3A249N. 7/31/2013, KOKC.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: N/A
Aircraft Configuration:
Nickname: N56
Tail Number: N56
Aircraft Type: LR-60
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Geographic Location:
Airport: IND/KIND - 14/32
Narrative:
After completing an ADS-B inspection in the Indy Tracon area, while on vectors to final landing at KIND, the #2 engine began oscillating. The PF first noticed the N2 needle quivering, then increasing to an oscillation between 80.0-82.0%, while the #1 engine N2 was set at 83.5%. With the #1 engine N1 set at 58.1%, and SYNC turned ON, the #2 engine N1 oscillated between 50.5-55.0%. The FF, and ITT also oscillated slightly, all within limits, while the Oil Temp/Press were steady and normal. With SYNC turned OFF, the oscillations continued. Crew could feel very slight yaw oscillations, but controllability was never an issue. PNF reviewed the Engine Shutdown In Flight and Engine Failure During Approach checklists. Moving the #2 throttle did not worsen or improve the oscillations. Since the engine was not exceeding any limitations, the crew elected to monitor the motor and continue to an uneventful landing at KIND. Weather was VMC, winds 130-8.
Phase of Flight:
Flight Phase at Start of Event: Approach
Cause
Narrative:
Unsure why the #2 motor began to oscillate.
Detection
How Event Detected:
Self Awareness/Scan: Yes
When Event Detected:
In-Flight: Yes
Reaction

Flight Crew:
Operated in Degraded Conditions: Yes
Flight Status after Event:
No Disruption: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 634

Overview:
Processing:
Status: Closed
ID: 634
Date/Time When Event Occurred: Thu, 18 Jul 2013 17:30 Z
Local Time When Event Occurred: 12:30
Viewer Accessible: Yes
Initial Notification Date/Time: Thu, 18 Jul 2013 19:58 Z
Submission Date/Time: Thu, 18 Jul 2013 19:58 Z
Source: Web Submission
Form Name: submission-form
Debrief Narrative: 7/19/13 Removed and replaced landing gear handle assy. by removing edge lite panel, removed 4 screws and cannon plug. Installed assy. cannon plug, 4 screws and edge lite panel. Operational check satisfactory IAW TI 4128.2, ch. 32-30-00.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
ATC Radio Frequency (MHz): 119.3
Name of ATC Facility: Amarillo Approach Control
Aircraft Configuration:
Nickname: N69
Tail Number: N69
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Geographic Location:
Airport: AMA/KAMA - 13/31
Waypoint/Fix: MOVOE
Narrative:
Pilot flying moved landing gear lever to lower gear at final approach fix. There was no sound or light indication. Tried a second time with no effect. Called tower and was cleared to climb outbound VFR. Pilot not flying called FICO using ARINC VHF and requested diversion to KOKC. This was approved. Pilot not flying then requested and was issued IFR clearance to KOKC by Amarillo Approach Control. Landing gear remained retracted until the aircraft leveled at 4000 MSL approximately 15 nm west of KOKC. The Landing Gear Manual Extension Abnormal Checklist was completed. The manual landing gear extension was successful. The three green landing gear lights illuminated and the red lights in the gear handle extinguished. Landing, roll out and taxi to the FAA ramp was uneventful.
Phase of Flight:
Flight Phase at Start of Event: Approach
Cause
Narrative:
The reason will be discovered once the aircraft is on jacks.
Detection
How Event Detected:
Self Awareness/Scan: Yes
When Event Detected:
In-Flight: Yes
Reaction

Flight Crew:
Contacted ATC: Yes
Contacted Operations: Yes
Executed Missed Approach: Yes
Flight Status after Event:
Diversion: Yes
Suggestions
Narrative:
No suggestions at this time.

Deidentified Crewmembers Analyst SSE Report 633

Overview:
Processing:
Status: Closed
ID: 633
Date/Time When Event Occurred: Mon, 15 Jul 2013 20:15 Z
Local Time When Event Occurred: 14:15
Viewer Accessible: Yes
Initial Notification Date/Time: Tue, 16 Jul 2013 00:00 Z
Submission Date/Time: Tue, 16 Jul 2013 00:00 Z
Source: Web Submission
Form Name: submission-form
Debrief Narrative: 7/16/13 #2 ATC reciever shows fail light. After further inspection burning electrical smell coming from inside reciever. Pulled #2 ATC CB and collared #2 AFIS ATC.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: N/A
Aircraft Configuration:
Nickname: N57
Tail Number: N57
Aircraft Type: LR-60
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Geographic Location:
Airport: BIL/KBIL
Narrative:
During pre-starting checks with aircraft batteries on and APU running, and all systems (AFIS, Avionics) operating, a distinct acrid odor was noted, and the mission specialist stated that a slight amount of grey smoke could be observed in the cabin. All systems operated normally and no circuit breakers tripped. The smoke dissipated and after a few minutes the odor was less but still detectable but became stronger on occasion. Isolating the ACM and the VCS for cabin air source did not seem to effect the odor, and the air coming from those sources appeared normal. Aircraft was subsequently powered down and maintenance contacted for further investigaton. Flight canceled.
Phase of Flight:
Flight Phase at Start of Event: Predeparture/Preflight
Cause
Narrative:
Unknown.
Detection
How Event Detected:
Flight Crew: Yes
When Event Detected:
PreFlight: Yes

Reaction
Flight Crew:
Contacted Company: Yes
Contacted Maintenance: Yes
Flight Status after Event:
Flight Cancellation: Yes
Suggestions
Narrative:
None.

Deidentified Crewmembers Analyst SSE Report 632

Overview:
Processing:
Status: Closed
ID: 632
Date/Time When Event Occurred: Mon, 15 Jul 2013 16:20 Z
Local Time When Event Occurred: 09:20
Viewer Accessible: Yes
Initial Notification Date/Time: Mon, 15 Jul 2013 23:48 Z
Submission Date/Time: Mon, 15 Jul 2013 23:48 Z
Source: Web Submission
Form Name: submission-form
Debrief Narrative: 8/5/13 As of this date cannot locate corresponding record in ILM or paper logsheets

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: ZOA

Aircraft Configuration:

Nickname: N57

Tail Number: N57

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Navigational Aid/VORTAC: MUSTANG (FMG) - 350/50

Narrative:

During normal enroute climb to FL330, while passing through approximately FL270, a rapid increase in cabin altitude was noted visually on the pressurization controller; PRESS SYS light illuminated as expected, and emergency pressurization activated with cabin at approximately 9500. "Pressurization Loss at ALT or Cabin ALT Exceeds 8500" and "PRESS SYS" abnormal checklists complied with descent requested from ATC to ARTCC MIA; cabin altitude stabilized and then began a descent from 9500. While in descent below approximately 16000, the cabin descended below 8000. Pressurization system stabilized and at approximately 12000 the "Return to Normal Pressurization" abnormal checklist complied with. Pressurization system operated normally in manual mode. "Return to Automatic Mode" abnormal checklist complied with. Automatic mode worked normally and all abnormal annunciators and fault lights were extinguished. After discussion, crew requested a slow climb back to higher altitude; all systems performed normally and flight continued with close monitoring of pressurization system. The subsequent descent and then a climb back to FL350 and another descent for landing were normal while operating in automatic mode.

Phase of Flight:

Flight Phase at Start of Event: Climb

Cause

Narrative:

It appeared that an automatic pressurization fault occurred, possibly driving an outflow valve open; it either cleared itself or the pulling and resetting the system circuit breaker as per the "Return to Automatic Mode" checklist cleared the anomaly and the system subsequently operated normally.

Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
How Event Detected:
Flight Crew: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Contacted ATC: Yes
Operated in Degraded Conditions: Yes
Flight Status after Event:
No Disruption: Yes
Suggestions
Narrative:
None.

Deidentified Crewmembers Analyst SSE Report 631

Overview:
Processing:
Status: Closed
ID: 631
Date/Time When Event Occurred: Fri, 12 Jul 2013 18:00 Z
Local Time When Event Occurred: 14:00
Viewer Accessible: Yes
Initial Notification Date/Time: Mon, 15 Jul 2013 11:34 Z
Submission Date/Time: Mon, 15 Jul 2013 11:34 Z
Source: Web Submission
Form Name: submission-form
Debrief Narrative: 7/16/13REPLACED GROUND IDLE SOLENOID ASSY AND SADDLE BRACKET HARDWARE. RESET BOTH PROP LIGHT PARAMETERS. RESET BOTH FLT IDLE TORQUE VALUES. REINSTALLED ALL REMOVED SAFTIES AND COTTER PINS. GROUND RUN-OPS CHECKED GOOD - NO DISCREPANCIES NOTED -IAW TI4128.2
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: N/A
Aircraft Configuration:
Nickname: N70
Tail Number: N70
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Geographic Location:
Airport: FTY/KFTY - 08/26
Narrative:
Right Prop Pitch Light Illuminated Momentarily with Adverse Yaw After the Throttles Were Retarded for Landing. Normal Landing Was Made.
Phase of Flight:
Flight Phase at Start of Event: Landing
Cause
Narrative:
N/A
Detection

How Event Detected:
Flight Crew: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Corrected Pitch/Power: Yes
Flight Status after Event:
No Disruption: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 637

Overview:
Processing:
Status: Closed
ID: 637
Date/Time When Event Occurred: Thu, 11 Jul 2013 21:50 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Wed, 31 Jul 2013 14:48 Z
Submission Date/Time: Wed, 31 Jul 2013 14:48 Z
Source: Web Submission

Form Name: submission-form

Debrief Narrative: 8/5/13 Cannot locate logbook entry that corresponds to SSE write up.

7/11/13 RT PROP WENT TO GRND FINE @ 100' AGL, USED RUDDER AND POWER TO KEEP ON GOV Correction: 7/14/13 R/RED R/H GRD STOP SOLENOID, FWD REV CLEVIS, R/H PWR INPUT LEVER. ADJUSTED R/H AND L/H ENG TQ SREWS, R/H INTERCONNECTING ROD. LENTHENED R/H REV CAB;LE APPROX .075. ADJUSTED MAX REV STOP SCREW. OPERATION AND PERFORMANCE ALL FOUND GOOD. C/W ENG RUN CARDS 1504. 1502.

7/15/13 ON LANDING A/C DID NOT AUTOMATICALLY GO INTO GRND FINE. 10 SECONDS NO AUTO. Correction: 7/15/13 COULD NOT DUPLICATE DISCRPENY IN HANGAR. REMOVED AND REPLACED R/H MLG SAFETY SWITCH P/N 101-364628-3 AND PRINTED CIRCUIT BOARD (SERVICEABLE FROM n67) SWITCH ADJUSTED IAW TI4128.2 CH 32 PROCEDURES.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: N/A

Aircraft Configuration:

Nickname: N80

Tail Number: N80

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: ACY/KACY - 04/22

Narrative:

Very short final at approx 100' AGL, RT PROP PITCH caution light illuminated. No yaw, sound changes or erratic engine indications were observed with light. Additionally, props were still indicating 1700 rpm. At 50' props were matched at 1500 rpm and coming down together. PNF (PIC) instructed PF (SIC) to continue with power on landing. We were carrying approx 8 kts above VRef and power was still applied (non-idle condition). At approx. 5 feet, power was reduced slowly to idle and after landing aircraft began to pull to the right but was arrested and corrected with rudder and brakes. Nominal rollout and taxi back to hanger.

Phase of Flight:

Flight Phase at Start of Event: Landing

Cause

Narrative:

I fly 'em; I don't fix 'em.
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Landed in Emergency Condition: Yes
Flight Status after Event:
No Disruption: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 627

Overview:
Processing:
Status: Closed
ID: 627
Date/Time When Event Occurred: Wed, 03 Jul 2013 17:55 Z
Local Time When Event Occurred: 12:55
Viewer Accessible: Yes
Initial Notification Date/Time: Wed, 03 Jul 2013 19:55 Z
Submission Date/Time: Wed, 03 Jul 2013 19:55 Z
Source: Web Submission
Form Name: submission-form
Debrief Narrative: 7/3/13 LUBED DOOR PLUNGERS, OPS CK GOOD IAW TI 4107.2 CHAP 52-70-00.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: Kansas City ARTCC
Aircraft Configuration:
Nickname: N56
Tail Number: N56
Aircraft Type: LR-60
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Geographic Location:
Waypoint/Fix: SGF SPRINGFIELD
Narrative:
During cruise at FL340 from KSTL to KOKC, the red ENTRY DOOR light began flashing. PIC and SIC referenced the "ENTRY DOOR/AFT CAB DOOR Light" Emergency Checklist, and continued flight since there was no evidence of door failure. The light extinguished approximately 15 minutes later. Crew wrote up discrepancy upon landing at KOKC. Cabin differential was 8.5 psid and steady.
Phase of Flight:
Flight Phase at Start of Event: Cruise
Cause
Narrative:
Unsure why light illuminated. Possible failed proximity switch.
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
How Event Detected:
Flight Crew: Yes
When Event Detected:

In-Flight: Yes
Reaction
Flight Status after Event:
No Disruption: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 630

Overview:
Processing:
Status: Closed
ID: 630
Date/Time When Event Occurred: Fri, 28 Jun 2013 16:30 Z
Local Time When Event Occurred: 12:30
Viewer Accessible: Yes
Initial Notification Date/Time: Fri, 05 Jul 2013 14:28 Z
Submission Date/Time: Fri, 05 Jul 2013 14:28 Z
Source: Web Submission
Form Name: submission-form
Debrief Narrative: Removed and replaced #2 inverter power relays. Ops check good at this time. Work completed by Dan Rynbrandt, from BTL working @ PIT, RU3A249N, 6/28/13.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: N/A
Aircraft Configuration:
Nickname: N74
Tail Number: N74
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Geographic Location:
Airport: PIT/KPIT
Narrative:
10 minutes aftr takeoff, #2 inverter fail annunciator/master warning indication. Accomplished checklist, returned for landing at KPIT.
Phase of Flight:
Flight Phase at Start of Event: Climb
Cause
Narrative:
Aircraft malfunction.
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Status after Event:
Air Turnback: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 626

Overview:
Processing:

Status: Closed

ID: 626

Date/Time When Event Occurred: Fri, 28 Jun 2013 13:45 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 28 Jun 2013 17:54 Z

Submission Date/Time: Fri, 28 Jun 2013 17:54 Z

Source: Web Submission

Form Name: submission-form

Debrief Narrative: 6/28/13 DRAINED MOISTURE(WATER) FROM LEFT ENGINE FADEC. INSPECTED, CLEANED, AND RESEATED LT FADEC CONNECTORS. OPERATION CHECK P1/T1 SENSOR PROBES -CHECK GOOD. RAN ENGINES OP CHECKS GOOD IAW T14107.7-2 CHAPTER 73-20-02 AND 72-00-02.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: N/A

Aircraft Configuration:

Nickname: N56

Tail Number: N56

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Navigational Aid/VORTAC: CHARLESTON (HVQ) - 50/120

Narrative:

During descent to KCRW the white L ENG CMPTR annunciator illuminated. The "White ENG CMPTR Light" abnormal checklist was accomplished (TAB 9). The light remained illuminated so we diverted to KOKC. FICO was notified of the status of the aircraft and the change of destination via ARINC. Approximately one hour later the light extinguished on it's own. The white L ENG CMPTR annunciator illuminated again during the landing flare at KOKC and remained on until engine shutdown.

Phase of Flight:

Flight Phase at Start of Event: Descent

Cause

Narrative:

Unknown

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Status after Event:

Diversion: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 629

Overview:

Processing:

Status: Closed

ID: 629

Date/Time When Event Occurred: Thu, 27 Jun 2013 17:30 Z

Local Time When Event Occurred: 13:30

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 05 Jul 2013 14:25 Z

Submission Date/Time: Fri, 05 Jul 2013 14:25 Z

Source: Web Submission

Form Name: submission-form

Debrief Narrative: 6/28/13 Remove ac power monitor p/n 101-384175-1 s/n 0435 and installed overhauled AC power monitor p/n 101-384175-1 s/n 86. Cleaned solenoid grd. terminals behind r/h leading edge inspected wiring, found no defect at this time. Inverter ops check good at this time IAW TI 4128.2-1 Chap 24.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: N/A

Aircraft Configuration:

Nickname: N74

Tail Number: N74

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Geographic Location:

Airport: PIT/KPIT

Narrative:

10 minutes into flight, #2 inverter fail annunciator/master warning indication. No loss of AC power. Notified Pittsburgh approach of our problem and returned to land at KPIT.

Cause

Narrative:

Aircraft malfunction.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Status after Event:

Air Turnback: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 628

Overview:

Processing:

Status: Closed

ID: 628

Date/Time When Event Occurred: Wed, 26 Jun 2013 15:30 Z

Local Time When Event Occurred: 11:30

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 05 Jul 2013 14:20 Z

Submission Date/Time: Fri, 05 Jul 2013 14:20 Z

Source: Web Submission

Form Name: submission-form

Debrief Narrative: 6/27/13 Removed and replaced #2 inverter IAW TI 4128.2-1. Ops checked good IAW ref Ch 24-20-00. Dan David A&P 3196058, Jett Pro, PIT

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: N/A

Aircraft Configuration:

Nickname: N74

Tail Number: N74

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Geographic Location:

Navigational Aid/VORTAC: MONTOUR (MMJ) - 350/35

Narrative:

Cruise flight, had a #2 inverter fail annunciator/master warning indication. No loss of AC power. Accomplished memory item/checklist. Diverted to KPIT, 35 miles away.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Aircraft malfunction.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Status after Event:

Diversion-Other Alternate: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 625

Overview:

Processing:

Status: Closed

ID: 625

Date/Time When Event Occurred: Tue, 25 Jun 2013 16:06 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 26 Jun 2013 16:49 Z

Submission Date/Time: Wed, 26 Jun 2013 16:53 Z

Source: Paper Submission

Form Name: submission-form

Debrief Narrative: Adjusted R/H engine Beta Arm IAW TI 4128.2 ch 76 for smooth operation. Engine run OPS checked good. Work performed by Mark Ingram, 6/26/13, RU3A249N, KOKC.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: NA

Aircraft Configuration:

Nickname: N70

Tail Number: N70

Aircraft Type: BE-300

Geographic Location:

Airport: BNA/KBNA - 02R/20L

Narrative:

On a VFR landing at KBNA RWY 20L, during the flare as power was reduced to flight idle the aircraft yawed excessively to the right. Control of the aircraft was maintained and landing roll out was uneventful.

Cause

Narrative:

-

Detection

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 624

Overview:

Processing:

Status: Closed

ID: 624

Date/Time When Event Occurred: Mon, 24 Jun 2013 17:20 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 24 Jun 2013 21:35 Z

Submission Date/Time: Mon, 24 Jun 2013 21:35 Z

Source: Web Submission

Form Name: submission-form

Debrief Narrative: 7/8/13 PRATT & WHITNEY ENGINE SERVICES DUE TO TEMPERATURE EXCEEDENCE REMOVED AND REPLACED RIGHT ENGINE ASSY. ALL WORK C/W BY P&W REPAIR STATION L2QR166Y PERSONNEL. OPERATION AND LEAK CHECKS C/W AND FOUND SATISFACTORY BY P&W PERSONNEL. ENG S/N PCE305132 REMOVED S/N PCE305233 INSTALLED. AIRCRAFT T.T. 7,427.7 T.L. 3533.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: N/A

Aircraft Configuration:

Nickname: N54

Tail Number: N54

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Airport: KN96 - 07/25

Narrative:

During commissioning inspection of KN96, Bellefonte, PA. RNAV (GPS) RWY 25, the master caution annunciator and the Amber "RT ENG CMPTR" annunciator illuminated. The "In Flight, Amber ENG CMPTR Light", abnormal checklist (Tab 8) was completed. The light remained illuminated, flight inspection was terminated and we diverted to KACY for maintenance. FICO was notified of the change of destination and aircraft status via ARINC.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Unknown

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Status after Event:

Diversion: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 621

Overview:

Processing:

Status: Closed

ID: 621

Date/Time When Event Occurred: Tue, 21 May 2013 00:52 Z

Local Time When Event Occurred: 13:30

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 04 Jun 2013 20:04 Z

Submission Date/Time: Tue, 04 Jun 2013 20:05 Z

Source: Web Submission

Debrief Narrative: 5/22/13 Found EVA tube blew off at the manifold. Blue tube was used as an extension between EVA tube and manifold. Removed blue tube and replaced with grey EVA tubing. Reconnect EVA tube and ran engines for ops check. Ops check - good.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: New Orleans Approach

Aircraft Configuration:

Nickname: N70

Tail Number: N70

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: MSY/KMSY

Narrative:

Right Bleed Air Fail Light - Bleed switch moved to Pneu/Environ Off.

Referenced checklist for clean-up items.

Requested redispach to KFTY for required maintenance.

Phase of Flight:

Flight Phase at Start of Event: Holding

Cause

Narrative:

Please reference maintenance write-up and corrective action.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Company: Yes

Flight Status after Event:

Diversion-Other Alternate: Yes

Suggestions

Narrative:

Please coordinate between ops and maint to help prevent further failures.

Deidentified Crewmembers Analyst SSE Report 620

Overview:

Processing:

Status: Closed

ID: 620

Date/Time When Event Occurred: Thu, 16 May 2013 19:40 Z

Local Time When Event Occurred: 14:40

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 17 May 2013 01:01 Z

Submission Date/Time: Fri, 17 May 2013 19:35 Z

Source: Web Submission

Debrief Narrative: As of 6/5/13 event has not been recorded on the logbooks or in ILM.

As of 7/17/13 event WAS NOT recorded on the aircraft logsheets. Unable to provide a maintenance response.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N56

Tail Number: N56

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Airport: K6D9 - 08/26

Narrative:

During check of the PROC/G final approach course at 6D9, the Master caution illuminated along with the amber ELEC PWR annunciator. The annunciation went away almost immediately but then repeated several times during climbout. In conjunction with the lights the electric power monitor (EPM) left VAC indication fluctuated between 105 and 0. Inspection was terminated. The "ELEC PWR light" and the "AC Bus Failure (Full or Partial)" abnormal checklists were followed. Upon completion of the checklists the left inverter operated normally and flight inspection was resumed.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Unknown

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 618

Overview:

Processing:

Status: Closed

ID: 618

Date/Time When Event Occurred: Thu, 09 May 2013 16:30 Z

Local Time When Event Occurred: 12:30

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 09 May 2013 20:14 Z

Submission Date/Time: Thu, 09 May 2013 20:15 Z

Source: Web Submission

Debrief Narrative: 5/13/13 TROUBLESHOT SYSTEM AND FOUND BAD WEIGHT ON WHEELS HARNESS. REMOVED AND REPLACED HARNESS IAW TI 4109.2 CHAPTER 32-20-41. SYSTEM OP CK GOOD

Deferred with DMI Number: 314

A SFP has been issued for a one-time flight from ACY to OKC.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N86

Tail Number: N86

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: KHEF - 16L/34R

Narrative:

Upon completion of a low approach gear was selected up for climb out. After mains retracted nose gear remained extended, and red light in handle continued flashing. Nose gear door open light initially was not illuminated (light tested good). We executed published missed and entered holding. In holding we referenced checklist Gear Up Disagree (E-43), transferred flight controls and called FICO for conference with maintenance and standards teams. While talking to standards and Mx the Nose Gear Door light illuminated approximately 40 minutes after the initial malfunction. We recovered the aircraft to ACY as directed by FICO, referenced and followed the nose gear door open and gear up disagree light checklists, manually extended the gear and landed uneventfully. We rolled the A/C to the end of the runway pinned the gear, stowed the manual release handle, and taxied to the ramp.

Phase of Flight:

Flight Phase at Start of Event: Go Around

Cause

Narrative:

Do not know why this event occurred.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Executed Missed Approach: Yes

Operated in Degraded Conditions: Yes

Flight Status after Event:

Precautionary Landing: Yes

Diversion-Other Alternate: Yes

Diversion: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 617

Overview:

Processing:

Status: Closed
ID: 617
Date/Time When Event Occurred: Tue, 07 May 2013 11:15 Z
Local Time When Event Occurred: 13:15
Viewer Accessible: Yes
Initial Notification Date/Time: Wed, 08 May 2013 07:12 Z
Submission Date/Time: Wed, 08 May 2013 07:12 Z
Source: Web Submission
Debrief Narrative: 5/7/13 Inspected aircraft, no damage found.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: Ramstein Tower

Aircraft Configuration:

Nickname: N85

Tail Number: N85

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: ETAR - 09/27

Narrative:

During an ILS-3 flight inspection low approach to RWY 9, two hawk-sized birds crossed our flight path. We avoided the first one but heard and felt the second bird hit the aircraft near the nose. No adverse effects noted; aircraft engines and hydraulics continued to operate normally. We left the gear down and flaps at 20 degrees, and continued the flight inspection. We notified tower, they reported that they did not find any remains on the runway. Post-flight inspection revealed no damage, and no remains of the bird were found.

Phase of Flight:

Flight Phase at Start of Event: Go Around

Cause

Narrative:

We did not see the second bird until just before impact. Evasion options are limited during ILS-3 maneuvers due to our low altitude.

Detection

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 616

Overview:

Processing:

Status: Closed

ID: 616

Date/Time When Event Occurred: Fri, 03 May 2013 13:45 Z

Local Time When Event Occurred: 09:45

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 03 May 2013 14:25 Z

Submission Date/Time: Fri, 03 May 2013 14:25 Z

Source: Web Submission

Debrief Narrative: 5/3/13 Removed and replaced R/H power lever switches. Performed ops check, checked good at this time.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 126.825

Name of ATC Facility: KBTL

Aircraft Configuration:

Nickname: N76

Tail Number: N76

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Airport: BTL/KBTL - 05/23

Narrative:

During run up auto feathers checked SAT. During power up on take-off roll auto feathers armed at approx. 80 kts plus the left auto feather light went out. Take off aborted. Stopped on runway, did a run up and auto feather armed. Began a second take off roll and at approx. 80 kts plus the left auto feather light went out again. Take off aborted. Advised ATC both times and returned to FAA ramp. Advised BTL Maint, wrote up the aircraft and Fico.

Phase of Flight:

Flight Phase at Start of Event: Rejected Takeoff

Cause

Narrative:

This is a recurring problem with N76. Maint is trying to determine the problem.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Contacted Maintenance: Yes

Flight Status after Event:

Flight Delay: Yes

Rejected Takeoff: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 615

Overview:

Processing:

Status: Closed

ID: 615

Date/Time When Event Occurred: Wed, 01 May 2013 17:25 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 02 May 2013 18:22 Z

Submission Date/Time: Thu, 02 May 2013 18:24 Z

Source: Fax

Debrief Narrative: 5/7/13 Removed And Replaced L/H pilots side window, IAW MM 56-10-16

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N87

Tail Number: N87

Aircraft Type: CL-601

Narrative:

Departed PANC for FI mission in the PATC area. Passing FL30 for LF 350, the crew heard a loud pop. Initial inspection discovered L Pilot side window with large crack and significant gap in outer pane with associated FAIL light on windshield heat. Began a slow descent and turned toward PANC while accomplishing abnormal checklist. Crew elected not to continue FI mission due to the isolated area where inspections were and further delamination could result in engine damage. Crew discussed burning fuel down to avoid overweight landing inspection but elected to land immediately instead. Crew briefed heavy weight landing considerations (landing dist, airspeed, ground speed, VVI, go around point, etc). Set up extended final, touchdown occurred on Vref at less than 200VVI with 9,000' remaining. Taxi back/shutdown with no issues.

Cause

Narrative:

-

Detection

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 614

Overview:

Processing:

Status: Closed

ID: 614

Date/Time When Event Occurred: Wed, 01 May 2013 04:50 Z

Local Time When Event Occurred: 23:50

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 02 May 2013 01:03 Z

Submission Date/Time: Thu, 02 May 2013 01:03 Z

Source: Web Submission

Debrief Narrative: 5/1/13 Took samples for bird strike kit. Cleaned and inspected area around bird strike's with no defects noted. Inspected aircraft for additional bird strikes with none found. Work accomplished IAW TI 4143.13-20-1 by Joel Randall @ Landmark Aviation, A&P 3569211, KUGN, 5/1/13.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 128.15

Name of ATC Facility: ORD Tower

Aircraft Configuration:

Nickname: N74

Tail Number: N74

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Airport: ORD/KORD - 09L/27R

Narrative:

While on ILS 3 for ORD 9L at 0450Z over the approach lights, crew saw a white streak, and heard a thump of a bird striking aircraft. Previously at 0313Z, crew heard a slight thump and noticed a small bird had struck the pilots windshield leaving a slight streak of remains. No apparant damage to the aircraft. Crew continued mission.

On post flight inspection the crew noticed a small amount of remains on the pilots windshield and right inboard wing. An log book entry was made. Maintenance inspected aircraft and collected remains. No damage to airframe.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Aircraft and bird tried to occupy the same airspace.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Returned to Assigned Altitude: Yes

Returned to Assigned Course/Heading: Yes

Returned to Assigned Speed: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Narrative:

None.

Deidentified Crewmembers Analyst SSE Report 613

Overview:

Processing:

Status: Closed

ID: 613

Date/Time When Event Occurred: Fri, 12 Apr 2013 16:06 Z

Local Time When Event Occurred: 12:06

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 12 Apr 2013 20:18 Z

Submission Date/Time: Fri, 12 Apr 2013 20:38 Z

Source: Web Submission

Debrief Narrative: 4/17/13 Found beta rod bushing pushed out of position. Removed and replaced left propeller and rig. Ops and performance checked good IAW WC 300-1206, 300-1207, and 300-1502. TI 4128.2 Ch 76 RII by Eric Morehouse, BTL

Left engine ground idle solenoid due replacement by Maintenance Management request.

Removed and replaced left engine gound idle solenoid IAW TI 4128.2 Chapt 76. Rig and ops check good IAW the same. RII C/W by Eric Morehouse, BTL

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N69

Tail Number: N69

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Geographic Location:

Airport: TOL/KTOL - 07/25

Narrative:

During landing sequence at KTOL, aircraft was on centerline to RWY 25 configured for landing with props set at 1700 RPM, gear down, flaps set full down. Before Landing and Final Items checklists completed. At approx 50' AGL and 115kts, power levers were reduced to idle, at that time aircraft yawed at least 40 degrees left accompanied by a change in prop noise coming from the left side. Immediate power was applied and a go-around was initiated. Aircraft entered the downwind leg for a second landing attempt on RWY 25. Since there is no approved emergency procedure in our documentation for such an event, PIC elected to configure the aircraft for landing at 1500 prop RPM and land while carrying power through to touchdown - as per discussions at Simuflite / Dallas and internal office safety collaborations. Before Landing checklist was reverified and aircraft landed uneventfully in the new configuration.

Phase of Flight:

Flight Phase at Start of Event: Landing Flare

Cause

Narrative:

Appears that the left prop pitch decreased below the flight idle stop in flight.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Executed Go Around: Yes

Flight Status after Event:

Precautionary Landing: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 612

Overview:

Processing:

Status: Closed

ID: 612

Date/Time When Event Occurred: Tue, 02 Apr 2013 16:15 Z

Local Time When Event Occurred: 10:15

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 03 Apr 2013 14:27 Z

Submission Date/Time: Wed, 03 Apr 2013 14:28 Z

Source: Web Submission

Debrief Narrative: 4/2/13 ADJUSTED LH AND RH SPOILER FOLLOW-UPS IAW TI 4107.2 CHAPTER 27-10-06. OPS CK'D GOOD

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N54

Tail Number: N54

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Airport: KM78 - 04/22

Narrative:

During obstacle check/low approach to KM78 RWY 22, the "SPOILER MON" annunciator illuminated along with the master caution light. At the time of annunciation the aircraft was configured with landing gear down, flaps 20', spoilers not armed. Subsequently the gear and flaps were retracted with no change to the annunciation. The abnormal checklist "SPOILER MON LIGHT IN FLIGHT" was followed but the annunciator did not clear so the CB was pulled IAW the abnormal checklist. We elected to divert/return to KOKC for maintenance. The abnormal checklist "SPOILERS FAILED LANDING" was followed and landing was without incident.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Reason for annunciator unknown/not evident to flight crew.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Status after Event:

Diversion: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 609

Overview:

Processing:

Status: Closed

ID: 609

Date/Time When Event Occurred: Thu, 14 Mar 2013 15:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 15 Mar 2013 13:32 Z

Submission Date/Time: Fri, 15 Mar 2013 13:32 Z

Source: Web Submission

Debrief Narrative: The ramp is now swept monthly by a properly-equipped truck.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Geographic Location:

Airport: OKC/KOKC

Narrative:

I was approached by an FIS crew member regarding Foreign Object Debris (FOD) on the FAA ramp. This FOD was in the form of screws, nails, and other construction debris found on the FAA Ramp. The concern is that this will be ingested by an engine or damage aircraft tires.

Phase of Flight:

Flight Phase at Start of Event: Non-Flight

Cause

Narrative:

Possibly from nearby construction activity.

Detection

When Event Detected:

PreFlight: Yes

Ramp: Yes

Reaction

Suggestions

Narrative:

Crewmember suggestion is to outfit FIS ramp vehicles with magnetic sweepers that will pick up metallic FOD in the course of normal operations.

Deidentified Crewmembers Analyst SSE Report 608

Overview:

Processing:

Status: Closed

ID: 608

Date/Time When Event Occurred: Thu, 07 Mar 2013 17:05 Z

Local Time When Event Occurred: 11:05

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 08 Mar 2013 17:57 Z

Submission Date/Time: Fri, 08 Mar 2013 17:57 Z

Source: Web Submission

Debrief Narrative: Aircraft ferried under special flight permit to KOKC . Deferred with DMI Number: 174 REMOVED AND REPLACED LANDING GEAR CONTROL VALVE, R/T UP LOCK SWITCH AND L/H DOWN LOCK SWITCH IAW TI.4107.CH 32 OPS CHECKED GOOD.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 122.9

Name of ATC Facility: KM85 CTAF

Aircraft Configuration:

Nickname: N55

Tail Number: N55

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

On climb out following a low approach at Gideon, MO (KM85), PF called for landing gear up. PNF raised the landing gear handle but the landing gear did not retract. PIC (PF) directed the PNF to return the landing gear handle to the down position. The landing gear remained down and locked. The crew contacted the FICO and the decision was made to divert to Spirit of St Louis (KSUS). The flight continued to KSUS with the landing gear extended. The landing was uneventful.

Phase of Flight:

Flight Phase at Start of Event: Go Around

Cause

Narrative:

Unknown

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Operated in Degraded Conditions: Yes

Flight Status after Event:

Diversion: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 606

Overview:

Processing:

Status: Open

ID: 606

Date/Time When Event Occurred: Mon, 04 Mar 2013 13:00 Z

Local Time When Event Occurred: 08:00

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 04 Mar 2013 15:00 Z

Submission Date/Time: Mon, 04 Mar 2013 15:00 Z

Source: Web Submission

Debrief Narrative: 6/5/13 NOTE this will not have a normal maintenance response. The corrective action will come through the aircraft configuration team.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Aircraft Type: BE-300

Narrative:

Safety Improvement Report submission regarding the pilot seat cushions in the BE300 Proline aircraft. The seat cushions tend to develop a lean towards the center console. This lean causes lower back discomfort after a short duration. This lean will probably cause and possibly exacerbate past back injuries. An injury could occur during turbulent flight. Several write up's have been annotated in the log books, resulting in replacement of the cushions. Because of the type of material or the installation process, the lean returns. The type of foam utilized is very different from what is currently installed in the legacy BE300.

Phase of Flight:

Flight Phase at Start of Event: Non-Flight

Cause

Narrative:

Type of cushion used.

Detection

How Event Detected:

Flight Crew: Yes

Reaction

Suggestions

Narrative:

Consider using the legacy type foam. Consider not trimming the cushion. Consider trimming both sides of the cushion. BE300 Proline SKANDIA PART # 00009322 BE300 Legacy SKANDIA PART # 00000604

Deidentified Crewmembers Analyst SSE Report 607

Overview:

Processing:

Status: Closed

ID: 607

Date/Time When Event Occurred: Wed, 27 Feb 2013 17:30 Z

Local Time When Event Occurred: 11:30

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 04 Mar 2013 20:12 Z

Submission Date/Time: Tue, 05 Mar 2013 17:20 Z

Source: Web Submission

Debrief Narrative: 6/5/13 Deferred with DMI Number: 272

5/17/13 A SFP has been issued for a one-time flight from FTY to OKC.

REMOVED LH WING, DISSASSEMBLED LE ASSY, REMOVED AND REPLACED OUTOARD WING LEADING EDGE ASSY (P/N: 000-110029-611). REMOVED AND REPLACED UPPER LE HINGE ASSEMBLIES IAW TI 4128.3, CHAP 20-08-00. REASSEMBLED WING ASSY, INSTALLED ON AIRCRAFT IAW TI 4128.2, CHAP 57-00-00, REPLACED DE-ICE BOOT AND LIFT TRANSDUCER-SEE CSN 701, 703 AND 705.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 133.75

Name of ATC Facility: Cairns Approach

Aircraft Configuration:

Nickname: N75

Tail Number: N75

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: KMAI

Navigational Aid/VORTAC: MARIANNA (MAI) - 136/1

Narrative:

Approaching the FAF on the VOR-A approach to KMAI three large birds (Turkey Buzzards) flew into our flight path. One bird struck the left wing leading edge near the stall vane creating a significant dent. The other two passed over the top of the wing without impacting the aircraft.

The Abnormal Checklist (Controllability Check) was used. No control problems were determined. FICO was then contacted via ARINC. FICO directed us to RTB KFTY.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Normal flight Inspection activities.

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Executed Missed Approach: Yes
Flight Status after Event:
Diversion: Yes
Suggestions
Narrative:
No suggestions submitted at this time.

Deidentified Crewmembers Analyst SSE Report 604

Overview:
Processing:
Status: Closed
ID: 604
Date/Time When Event Occurred: Wed, 20 Feb 2013 22:05 Z
Local Time When Event Occurred: 13:05
Viewer Accessible: Yes
Initial Notification Date/Time: Thu, 21 Feb 2013 00:18 Z
Submission Date/Time: Thu, 21 Feb 2013 00:18 Z
Source: Web Submission
Debrief Narrative: Removed and replaced left and right wing anti-ice thermal sensors and thermal switches (6 total) IAW 4109.2 30-11-26. Swapped left and right anti-ice modulating valves IAW 4109.2 30-11-11, Ops check good IAW 4109.2 30-11-00.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: ANC TWR
Aircraft Configuration:
Nickname: N87
Tail Number: N87
Aircraft Type: CL-601
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Narrative:
After takeoff, R wing anti-ice fail light illuminate (w/MC), crew complied with Wing Anti-Ice System Failure. Shortly after checklist completion, Wing Duct fail light illuminated (w/MC). R wing dollseye was tripped. Checklist completed. We called FICO and initiated a phone patch. Situation was discussed with Chief Pilot-mission continued.

Fourth write-up

Phase of Flight:
Flight Phase at Start of Event: Takeoff
Cause
Narrative:
??
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
How Event Detected:
Flight Crew: Yes
Self Awareness/Scan: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Contacted Maintenance: Yes

Flight Status after Event:

Air Turnback: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 602

Overview:

Processing:

Status: Closed

ID: 602

Date/Time When Event Occurred: Tue, 19 Feb 2013 23:36 Z

Local Time When Event Occurred: 14:36

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 20 Feb 2013 19:05 Z

Submission Date/Time: Wed, 20 Feb 2013 19:05 Z

Source: Web Submission

Debrief Narrative: REMOVED AND REPLACED PILOTS MODE SELECT SWITCH, OPS CHECK GOOD IAW 4109.2-2 22-10-00

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 122.9

Name of ATC Facility: PAOO CTAF

Aircraft Configuration:

Nickname: N87

Tail Number: N87

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

While in descent for holding-in-lieu, autopilot/FD "self selected" SPEED mode (40 KIAS). The autopilot was pitching up to 40 KIAS. The pilot flying immediately disengaged the autopilot to prevent a potential stall and altitude deviation. Aircraft should be considered non-RVSM certified.

Pilot mode(s) selected at time of failure: NAV and VNAV.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Failure to fix autopilot/FD.

Detection

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Override Automation: Yes

Returned to Assigned Altitude: Yes

Returned to Assigned Course/Heading: Yes

Flight Status after Event:

Air Turnback: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 603

Overview:

Processing:

Status: Closed

ID: 603

Date/Time When Event Occurred: Tue, 19 Feb 2013 20:52 Z

Local Time When Event Occurred: 11:52

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 20 Feb 2013 19:10 Z

Submission Date/Time: Wed, 20 Feb 2013 19:22 Z

Source: Web Submission

Debrief Narrative: Swapped 14th stag SOVs and Ops checked IAW TI 4109.2

Swapped 14th stag SOVs and Ops check IAW TI 4109.2 36-10-16

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 118.3

Name of ATC Facility: ANC TWR

Aircraft Configuration:

Nickname: N87

Tail Number: N87

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

After takeoff, R wing anti-ice fail light illuminate (w/MC), crew complied with Wing Anti-Ice System Failure. Shortly after checklist completion, Wing Duct fail light illuminated (w/MC). R wing dollseye was tripped. Checklist completed. We called FICO and initiated a phone patch. Situation was discussed with Chief Pilot-mission continued.

Third write-up

Phase of Flight:

Flight Phase at Start of Event: Takeoff

Cause

Narrative:

Failure to correct/resolve the issue

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Operated in Degraded Conditions: Yes

Suggestions

Narrative:

MX requested QAF flight, Ops elected to forgo the mx flight and continue FI mission.

Deidentified Crewmembers Analyst SSE Report 600

Overview:

Processing:

Status: Closed

ID: 600

Date/Time When Event Occurred: Wed, 13 Feb 2013 23:03 Z

Local Time When Event Occurred: 14:03

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 14 Feb 2013 19:46 Z

Submission Date/Time: Thu, 14 Feb 2013 19:46 Z

Source: Web Submission

Debrief Narrative: Removed and replaced FCC card, ops check good IAW 4109.2-2 22-10-00. Let autopilot run in approach mode for 1 Hour with no un-commanded mode changes. S. Riddle

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: anc ctr

Aircraft Configuration:

Nickname: N87

Tail Number: N87

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

While in holding, autopilot/FD "self selected" SPEED mode (40 KIAS). The autopilot was pitching up to 40 KIAS. The pilot flying immediately disengaged the autopilot to prevent a potential stall and altitude deviation. Aircraft should be considered non-RVSM certified.

Phase of Flight:

Flight Phase at Start of Event: Holding

Cause

Narrative:

The same unsafe card (N85) was re-seated and installed.

Detection

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Override Automation: Yes

Returned to Assigned Altitude: Yes

Took Evasive Action: Yes

Flight Status after Event:

Air Turnback: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 598

Overview:

Processing:

Status: Closed

ID: 598

Date/Time When Event Occurred: Wed, 13 Feb 2013 21:15 Z

Local Time When Event Occurred: 12:15

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 14 Feb 2013 19:32 Z

Submission Date/Time: Thu, 14 Feb 2013 19:32 Z

Source: Web Submission

Debrief Narrative: Removed and replaced Ant-Ice Control Box and Pressure Switch, Operational test good IAW TI 4109.2, 30-11-00. J Randall

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: anc

Aircraft Configuration:

Nickname: N87

Tail Number: N87

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

After takeoff, R wing anti-ice fail light illuminate (w/MC), crew complied with Wing Anti-Ice System Failure. Shortly after checklist completion, Wing Duct fail light illuminated (w/MC). R wing dollseye was tripped. Checklist completed. We called FICO and initiated a phone patch. Situation was discussed with Chief Pilot-mission continued. System re-set. Ater missed approach at first location, we received same system indications. All checklist items accomplished. Mission terminated.

Phase of Flight:

Flight Phase at Start of Event: Takeoff

Cause

Narrative:

Unknown.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Flight Status after Event:

Air Turnback: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 601

Overview:

Processing:

Status: Closed

ID: 601

Date/Time When Event Occurred: Wed, 13 Feb 2013 14:54 Z

Local Time When Event Occurred: 08:54

Viewer Accessible: Yes
Initial Notification Date/Time: Fri, 15 Feb 2013 20:10 Z
Submission Date/Time: Fri, 15 Feb 2013 20:10 Z
Source: Web Submission
Debrief Narrative: REMOVED AND REPLACED #3A HYD SYSTEM LOW PRESSURE SWITCH IAW TI 4109.2 CHAP 29-13-31, SYS LK AND OP CK GOOD.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
ATC Radio Frequency (MHz): 118.9
Name of ATC Facility: Soto Cano Tower
Aircraft Configuration:
Nickname: N86
Tail Number: N86
Aircraft Type: CL-601
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Geographic Location:
Airport: MHSC - 17/35
Narrative:
After rotation Hyd 3A pump low pressure light illuminated. We continued takeoff and climb to 1500AGL. The PNF ran the appropriate checklist and turned off the Hyd 3A pump. We were flying with Hebblethwaite (Mx) so the PIC expertly brought him into the discussion to maximize CRM. With the 3A pump secured everyone was comfortable continuing, in VFR conditions and within 10NM of the airfield.
Phase of Flight:
Flight Phase at Start of Event: Takeoff
Cause
Narrative:
After landing Mx trouble shot the issue and suspects a low pressure switch.
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Operated in Degraded Conditions: Yes
Flight Status after Event:
No Disruption: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 599

Overview:
Processing:
Status: Closed
ID: 599
Date/Time When Event Occurred: Tue, 12 Feb 2013 20:49 Z
Local Time When Event Occurred: 11:49
Viewer Accessible: Yes
Initial Notification Date/Time: Thu, 14 Feb 2013 19:42 Z
Submission Date/Time: Thu, 14 Feb 2013 19:42 Z
Source: Web Submission
Debrief Narrative: Reset FCC IAPS cards, system check ok IAW 4109.2-2 22-10-00

Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: homer radio
Aircraft Configuration:
Nickname: N87
Tail Number: N87
Aircraft Type: CL-601
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Narrative:
While engaged on approach, autopilot/FD "self selected" SPEED mode (40 KIAS). The autopilot was pitching up to 40 KIAS. The pilot flying immediately disengaged the autopilot to prevent a potential stall.
Phase of Flight:
Flight Phase at Start of Event: Approach
Cause
Narrative:
We discovered that maintenance had this issue on N85 and moved that card to N87. This is an UNSAFE practice!!
Detection
How Event Detected:
Flight Crew: Yes
Self Awareness/Scan: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Override Automation: Yes
Took Evasive Action: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 597

Overview:
Processing:
Status: Closed
ID: 597
Date/Time When Event Occurred: Tue, 12 Feb 2013 19:35 Z
Local Time When Event Occurred: 10:35
Viewer Accessible: Yes
Initial Notification Date/Time: Thu, 14 Feb 2013 19:25 Z
Submission Date/Time: Thu, 14 Feb 2013 19:25 Z
Source: Web Submission
Debrief Narrative: Performed wing anti-ice ops ck IAW TI 4109.2 chapt 30-11-00, ops ck good.

Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: ANC
Aircraft Configuration:
Nickname: N87
Tail Number: N87

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

After takeoff, R wing anti-ice fail light illuminate (w/MC), crew complied with Wing Anti-Ice System Failure. Shortly after checklist completion, Wing Duct fail light illuminated (w/MC). R wing dollseye was tripped. Checklist completed. We called FICO and initiated a phone patch. Situation was discussed with Chief Pilot-mission continued.

Phase of Flight:

Flight Phase at Start of Event: Takeoff

Cause

Narrative:

Unknown.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Operated in Degraded Conditions: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 595

Overview:

Processing:

Status: Closed

ID: 595

Date/Time When Event Occurred: Fri, 08 Feb 2013 17:43 Z

Local Time When Event Occurred: 10:43

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 08 Feb 2013 21:37 Z

Submission Date/Time: Fri, 08 Feb 2013 21:37 Z

Source: Web Submission

Debrief Narrative: 2/12/13 Event not recorded in logbook. Cannot provide Maintenance input or resolution.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: Salt Lake Center

Aircraft Configuration:

Nickname: N57

Tail Number: N57

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Navigational Aid/VORTAC: BURLEY (BYI) - 283/12

Narrative:

Burley VOR R-283/012 at 14000 feet holding on AAR. R Gen Amber annunciator illuminated. Abnormal Procedures Checklist depicted on Page A-10, Generator Failure (Single) consulted, R Gen Reset switch reset momentarily, Generator reset normally. Aircraft maneuvered into VFR conditions, no further recurrence.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Unknown

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 592

Overview:

Processing:

Status: Closed

ID: 592

Date/Time When Event Occurred: Tue, 29 Jan 2013 19:27 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 30 Jan 2013 14:40 Z

Submission Date/Time: Wed, 30 Jan 2013 14:46 Z

Source: Fax

Debrief Narrative: -- Inspected aircraft and left prop and surrounding areas for damage. Damaged areas includes upper left cowling, left exhaust stack and upper aft cowling. Replaced upper FWD cowling cannablized from A/C N75 ref TI 4128.2 chapter 71-10-00.

Work performed by Terry Dove, RU3A249N, KRDU, atl, 1/30/13.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N72

Tail Number: N72

Aircraft Type: BE-300

Geographic Location:

Airport: RDU/KRDU - 05R/23L

Narrative:

While on an ILS-2 maneuver, hit a large bird (Turkey Buzzard). Bird went through left propeller without contact and impacted right exhaust stack on left engine and top of left nacelle. No vibrations or controllability issues.

1500 AGL, 170 KIAS, Sky Clear, 2 seen 1 struck, not warned of birds, snarge mailed to Smithsonian.

Landed straight-in (RWY 05R) from ILS-2. Used descent and before landing checklist.

Aircraft status: Down awaiting inspection and repair.

Cause

Narrative:

-

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction
Flight Status after Event:
Precautionary Landing: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 591

Overview:
Processing:
Status: Closed
ID: 591
Date/Time When Event Occurred: Tue, 29 Jan 2013 18:30 Z
Local Time When Event Occurred: 13:30
Viewer Accessible: Yes
Initial Notification Date/Time: Tue, 29 Jan 2013 20:23 Z
Submission Date/Time: Tue, 29 Jan 2013 20:23 Z
Source: Web Submission
Debrief Narrative: 1/29/13 -- REMOVED AND REPLACED RIGHT GENERATOR OPS CHECK GOOD ON ENGINE RUN.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: ZNY
Aircraft Configuration:
Nickname: N54
Tail Number: N54
Aircraft Type: LR-60
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Narrative:
Level at FL250, during ZNY ADS-B inspection, RGEN annunciator illuminated. Accomplished abnormal checklist and reset generator. Generator failed again and was secured per the checklist. ADS-B inspection was terminated and we returned to KACY, landing without incident.
Phase of Flight:
Flight Phase at Start of Event: Cruise
Cause
Narrative:
Generator failed.
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Contacted ATC: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 593

Overview:
Processing:
Status: Closed
ID: 593
Date/Time When Event Occurred: Tue, 29 Jan 2013 01:45 Z

Local Time When Event Occurred: 16:45
Viewer Accessible: Yes
Initial Notification Date/Time: Wed, 30 Jan 2013 18:57 Z
Submission Date/Time: Wed, 30 Jan 2013 18:57 Z
Source: Web Submission
Debrief Narrative: 1/31/13-- INBD sensor harness on R/H strut broken, R&R'd harness IAW TI 4109.2 32-10-31, ops check good IAW TI 4109.2 32-47-00.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: Anchorage Approach
Aircraft Configuration:
Nickname: N86
Tail Number: N86
Aircraft Type: CL-601
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Geographic Location:
Airport: ANC/PANC
Narrative:
On approach to RY 7R at PANC, While performing the Before Landing Checklist, Left Inboard Fail light for Anti Skid check illuminate. Broke off approach, ran abnormal checklist, landed without incident.
Phase of Flight:
Flight Phase at Start of Event: Approach
Cause
Narrative:
N/A. Downed aircraft and turned over to Maint.
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Contacted ATC: Yes
Flight Status after Event:
No Disruption: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 590

Overview:
Processing:
Status: Closed
ID: 590
Date/Time When Event Occurred: Fri, 25 Jan 2013 23:30 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Sat, 26 Jan 2013 01:40 Z
Submission Date/Time: Mon, 28 Jan 2013 14:12 Z
Source: Fax
Debrief Narrative: 1/25/13 -- Replaced 2ea. bulbs in green safe indicator, ran gear through several cycles, ops check good IAW 4109.2 32-50-00 pg. 214.
Event: 1
Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N86

Tail Number: N86

Aircraft Type: CL-601

Geographic Location:

Airport: EDF/PAED

Narrative:

Upon gear extension for flight inspection low approach at PAED, right main gear down indicator did not illuminate. On climb out, left gear extended and ran emergency checklist. Did not get safe gear indication as result of checklist task. Declared an emergency with ANC Approach and entered VFR pattern with tower. Landed safely. Maintenance met aircraft clearing runway; gear pinned. Returned aircraft to FAA ramp. Maintenance determined blown indicator bulb was responsible. Aircraft maintenance completed and aircraft returned to service.

Cause

Narrative:

-

Detection

Reaction

Flight Crew:

Declared Emergency with ATC: Yes

Landed in Emergency Condition: Yes

Contacted Maintenance: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 589

Overview:

Processing:

Status: Closed

ID: 589

Date/Time When Event Occurred: Fri, 25 Jan 2013 07:15 Z

Local Time When Event Occurred: 01:15

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 25 Jan 2013 23:38 Z

Submission Date/Time: Fri, 25 Jan 2013 23:39 Z

Source: Web Submission

Debrief Narrative: 1/25/13 -- ADJUSTED LEFT AND RT FLIGHT IDLE TORQUES ADJUSTED LEFT LOW PITCH PROX SWITCHCH ADJUSTED LEFT AND RIGHT GROUND IDLE SOLENOIDS. WORK PERFORMED AND CHECKED GOOD IAW TI 4128.2, CHAPTER 76-00-00.

1/30/13 Left propeller replaced due to discovery of damage on the prop pitch control dome and cylinder.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N83

Tail Number: N83

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: OKC/KOKC - 13/31

Narrative:

At 22:12 CST, Brian Harrelson PF, Cindy Schultz PNF had following incident occur. During take off from Houston, Ellington Field, Tx. the left prop pitch light came on after V1 and went back off. The event was talked about while enroute because approximately 2 weeks prior this was the same aircraft that had the left engine go into ground idle during landing flare. It was decided to keep the prop's at 1500rpm during landing at Oklahoma City, OK. 01/25/2013 at 01:15 CST, during flare, the left prop pitch light did come on and stayed on. I feel that if all the conditions had been met (i.e. the prop been full forward during landing) the left prop would have gone to ground idle +1.0 degrees from flight idle +13 degrees during the flare.

Phase of Flight:

Flight Phase at Start of Event: Landing

Cause

Narrative:

Propeller control system malfunction that has not been resolved in the King Air fleet.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Corrected Pitch/Power: Yes

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Narrative:

Until maintenance has solved this problem, there are two options that can be used to prevent the propeller going into ground idle while airborne. The first option is to not bring the prop levers all the way forward during the landing phase. The second option is to pull the PROP GOV TEST circuit breaker located on the middle of the co-pilot circuit breaker panel. Pulling this circuit breaker will remove power from the ground idle low pitch solenoid. If you are experiencing a prop pitch light illuminating and want to test it to see if the prop is going to malfunction, at altitude you can put the gear down, props full forward and bring the power to idle. If malfunctioning, you will get a yawing motion toward the prop that is going into ground idle while airborne.

Deidentified Crewmembers Analyst SSE Report 588

Overview:

Processing:

Status: Closed

ID: 588

Date/Time When Event Occurred: Wed, 23 Jan 2013 18:00 Z

Local Time When Event Occurred: 12:00

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 23 Jan 2013 23:11 Z

Submission Date/Time: Wed, 23 Jan 2013 23:11 Z

Source: Web Submission

Debrief Narrative: The FICO staff agrees with the SSE finding and has changed its procedures so that failed #1 VHF radios will no longer be deferred under the MEL.

Operations submitted a manual change request to add a note to this item in the BE300 MEL stating that it is not applicable to VHF #1.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: N/A

Aircraft Configuration:

Nickname: N69

Tail Number: N69

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Airport: MSP/KMSP

Narrative:

Upon landing in MSP VHF #1 was written up in the aircraft log book as- "VHF #1 will not tx or rx". FICO Maint was advised and copy of the log book sheet was faxed in and crew broke for lunch. Upon return to the FBO I was advised by FICO Maint. that VHF #1 was placed on MEL under 23-1 and I documented the log book as such. I read the MEL and voiced concern to FICO Maint about the MEL reading - "May be inoperative provided it is not powered by an Emergency Power Source and not required for Emergency Procedures." It was my understanding that if there was a dual generator failure VHF #1 would be the only operational radio so under the guidelines in the MEL we could not accept it. FICO maint. advised me that they have deferred this item numerous times before and that this was never brought to their attention. FICO Maint. then spoke with an avionics expert in OKC and he assured them that if you are on battery power, have the gen ties closed and the avionics master turned on that you will have all comm radios available. FICO Maint then suggested that we should be good to go with the MEL. I then referenced the BE-300 TI 4040.28.2 Flight Crew Emergency Procedures checklist Vol 2 and it states clearly in a WARNING- Do not place the GEN TIES Switch in the MAN CLOSE position. This action reconnects the L and R Generator bus loads and severely limits the battery duration. The crew verified on the aircraft that with the battery switch on and avionics master on and the gen tie open that the only available comm radio was VHF #1. Crew then contacted FICO Maint and corrective action was taken to swap out VHF #1 with VHF #2 and the #2 radio was placed on the MEL.

Phase of Flight:

Flight Phase at Start of Event: Non-Flight

Cause

Narrative:

FICO maint was unaware that our emergency checklists called for the gen tie switch to remain open causing the only operational comm radio to be VHF#1.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

PreFlight: Yes

Reaction

Flight Crew:

Contacted Maintenance: Yes

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Narrative:

If the MEL calls for a system to be operational for emergency procedures FICO maint should reference the aircrew checklist.

Deidentified Crewmembers Analyst SSE Report 587

Overview:

Processing:

Status: Closed

ID: 587

Date/Time When Event Occurred: Mon, 07 Jan 2013 21:00 Z

Local Time When Event Occurred: 15:00

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 07 Jan 2013 22:01 Z

Submission Date/Time: Mon, 07 Jan 2013 22:02 Z

Source: Web Submission

Debrief Narrative: REMOVED AND REPLACED STALL PROTECTION COMPUTER IAW T.I. 4109.2 CHAP 27-39-36 AND PERFORMED OPERATIONAL TEST IAW T.I. 4109.2 CHAP 27-39-00. OPS CHECKED GOOD.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 128.4

Name of ATC Facility: KZFW

Aircraft Configuration:

Nickname: N87

Tail Number: N87

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Geographic Location:

Navigational Aid/VORTAC: WILL ROGERS (IRW) - 270/50

Narrative:

Stall Protection Fail lights illuminated during a Rudder Operational Check Flight. Accomplished checklist with no further incident

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Maintenance is investigating

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 586

Overview:

Processing:

Status: Closed

ID: 586

Date/Time When Event Occurred: Mon, 07 Jan 2013 18:14 Z

Local Time When Event Occurred: 13:14

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 07 Jan 2013 20:49 Z

Submission Date/Time: Mon, 07 Jan 2013 20:49 Z

Source: Web Submission

Debrief Narrative: 1/9/13-- Removed and replaced Bus Tie Relay Assy, Bus Tie Overcurrent sensor and Bus Tie control card. Ops check of system showed normal operation with no defects noted. REF TI4128.2 ATA 24-00.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: ATL APCH

Aircraft Configuration:

Nickname: N72

Tail Number: N72

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Airport: FTY/KFTY

Waypoint/Fix: ATL ATLANTA

Narrative:

Shortly after departing KFTY, the RIGHT DC GEN and LEFT GEN TIE annunciators illuminated in flight. SINGLE GENERATOR FAILURE checklist and GENERATOR TIE OPEN abnormal checklists completed by flight crew. An uneventful landing followed at KFTY.

Phase of Flight:

Flight Phase at Start of Event: Climb

Cause

Narrative:

Possible right generator failure and/or bus fault.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Flight Status after Event:

Diversion: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 585

Overview:

Processing:

Status: Closed

ID: 585

Date/Time When Event Occurred: Thu, 03 Jan 2013 22:30 Z

Local Time When Event Occurred: 16:30

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 07 Jan 2013 18:36 Z

Submission Date/Time: Mon, 07 Jan 2013 21:08 Z

Source: Web Submission

Debrief Narrative: 1/10/13-- REMOVED AND REPLACED THE LEFT ENGINE PROP GOV. IAW TI 4128.2 CHAP61-20-00, ENG RUN OP CK GOOD.

SEE LOGBOOK PAGE 85368 DATED 1/7/2013 FOR CORRECTIVE ACTIONS FOR THE HARD LANDING AND BENT PROP BLADES.

See second event SSE# 589 Initial event traced to damage in propeller pitch change dome and cylinder.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: St Louis Tower

Aircraft Configuration:

Nickname: N83

Tail Number: N83

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Airport: STL/KSTL - 12L/30R

Narrative:

On visual approach to Runway 30R at KSTL. Uneventful approach until the flare. In flare, with power in idle, aircraft approximately 3 to 5 feet above the runway, aircraft violently yawed to the left 30 to 40 degrees. I added partial power and applied rudder and

aileron to realign the aircraft track with the runway. Aircraft touched down hard, bounced, and resettled down aligned with the runway. Power was reduced to idle and remainder of roll out and taxi in was uneventful. Upon post flight inspection, all 4 prop blades on the right engine were bent at the tips. KSTL tower notified of possible prop strike on runway.

Phase of Flight:

Flight Phase at Start of Event: Landing Flare

Cause

Narrative:

Possible failure of the left engine flight idle low pitch stop resulted in violent yaw to the left.

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Corrected Pitch/Power: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 584

Overview:

Processing:

Status: Closed

ID: 584

Date/Time When Event Occurred: Wed, 19 Dec 2012 16:10 Z

Local Time When Event Occurred: 10:10

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 19 Dec 2012 22:40 Z

Submission Date/Time: Wed, 19 Dec 2012 22:40 Z

Source: Web Submission

Debrief Narrative: 12/21/12 REPLACED R/H MLG DOWN AND LOCKED SWITCH IAW TI4107.2 CHPT 32-60-01. PERFORMED NUMEROUS GEAR EXTENSION AND RETRACTION CHECKS WITH NO FAULTS NOTED. OPS CK GOOD.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N55

Tail Number: N55

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

Following a flight inspection low approach at Port Isabel, TX (KPIL) the landing gear handle was raised but the landing gear did not retract. All three green gear down indicator lights remained illuminated with the landing gear handle in the up position. The crew briefly discussed the abnormality and returned the gear lever to the down position. All three green gear down indicator lights remained illuminated and no further attempts were made to retract the landing gear. The Crew elected to go to San Antonio, TX (KSAT) for maintenance/repair. While enroute to KSAT, FICO contacted the crew via ARINC and directed the flight to Houston, TX (KIAH) where maintenance had been coordinated. The crew advised ATC of the situation and was cleared to KIAH where a Normal landing ensued. The aircraft was turned over to maintenance.

Phase of Flight:

Flight Phase at Start of Event: Initial Climb

Cause

Narrative:

Unknown. Maintenance in progress.
Detection
How Event Detected:
Self Awareness/Scan: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Contacted ATC: Yes
Contacted Company: Yes
Operated in Degraded Conditions: Yes
Flight Status after Event:
Diversion: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 583

Overview:
Processing:
Status: Closed
ID: 583
Date/Time When Event Occurred: Mon, 17 Dec 2012 23:24 Z
Local Time When Event Occurred: 17:24
Viewer Accessible: Yes
Initial Notification Date/Time: Tue, 18 Dec 2012 15:33 Z
Submission Date/Time: Tue, 18 Dec 2012 15:33 Z
Source: Web Submission
Debrief Narrative: Inspected aircraft N-89 for bird strike damage per pilot discrepancy. Inspected leading edge of wings per Bomb Challenger 604 MM TI 4105.2 Chapter 57-40-00. No damage found. Found slight remains below O2 panel door. Cleaned same, no damage noted. Chris White, AP 264930428, Heliworks, KPNS.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
ATC Radio Frequency (MHz): 122.8
Name of ATC Facility: UNICOM
Aircraft Configuration:
Nickname: N89
Tail Number: N89
Aircraft Type: CL-605
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Geographic Location:
Airport: KHEZ - 13/31
Narrative:
Post Flight Inspection. Noticed bird strike on right side of nose below O2 panel. We called FICO and talked with FICO MX. Logbook info faxed.
Phase of Flight:
Flight Phase at Start of Event: Go Around
Cause
Narrative:
We believe the strike occurred on the flight inspection low approach at KHEZ. We did not hear or feel the bird strike.
Detection
How Event Detected:
Flight Crew: Yes

When Event Detected:

PostFlight: Yes

Reaction

Flight Crew:

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Narrative:

Due to the numerous birds we saw on the low approach, we discontinued any more approaches at the airfield and advised traffic about the bird activity.

Deidentified Crewmembers Analyst SSE Report 582

Overview:

Processing:

Status: Closed

ID: 582

Date/Time When Event Occurred: Wed, 12 Dec 2012 20:17 Z

Local Time When Event Occurred: 15:17

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 13 Dec 2012 13:45 Z

Submission Date/Time: Thu, 13 Dec 2012 13:45 Z

Source: Web Submission

Debrief Narrative: Found EVA tube loose at attach line at manifold. Re attached line, re installed with new ring clamps. Removed and reinstalled FOM: center carpet, center floor panel aft of spar, right engine OB nacelle panel, end of EVA tube at firewall, supply air line at manifold performed ground ran ops check of bleed air warning lights was good. Work done IAW TI 4128.2 ATA 20-00-00.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 125.5

Name of ATC Facility: MIA APCH

Aircraft Configuration:

Nickname: N75

Tail Number: N75

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Navigational Aid/VORTAC: DOLPHIN (DHP) - 229/8

Narrative:

Right bleed air annunciator illuminated in flight. Crew accomplished "Bleed Air Fail" emergency checklist. An uneventful landing followed.

Phase of Flight:

Flight Phase at Start of Event: Holding

Cause

Narrative:

Possible bleed air leak.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

*In-Flight: Yes
Reaction
Flight Status after Event:
Diversion: Yes
Suggestions*

Deidentified Crewmembers Analyst SSE Report 581

*Overview:
Processing:
Status: Closed
ID: 581
Date/Time When Event Occurred: Tue, 11 Dec 2012 22:00 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Wed, 12 Dec 2012 20:41 Z
Submission Date/Time: Wed, 12 Dec 2012 20:41 Z
Source: Web Submission
Debrief Narrative: REMOVED AND REPLACED THE RIGHT WINDSHIED IAW TI 4109.2 CHAP56-10-11, LEAK CHECK GOOD.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
ATC Radio Frequency (MHz): 66555
Name of ATC Facility: SFO AIRINC
Aircraft Configuration:
Nickname: N86
Tail Number: N86
Aircraft Type: CL-601
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Narrative:
At FL350 approximately 45N152W we had a right side windshield anti-ice failure. Performed Windshield Anti-Ice Failure as directed in the abnormal procedure. Continued on original route to planned destination PHKO. Approximately 20 minutes later I noticed a crack of the outer ply of the right side (co-pilot) windshield. Crack ran from top to bottom about center screen. Performed abnormal procedure for Windshield Outer Face Ply Failure. Decided that based on our position and enroute conditions best course of action would be to change destination to PHNL. On descent into PHNL majority of outer ply of windshield seperated from the aircraft. Upon arrival at PHNL aircraft mechanic visually inspected aircraft for any further damage. No further damage apparent.
Phase of Flight:
Flight Phase at Start of Event: Cruise
Cause
Narrative:
Faulty windshield.
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
How Event Detected:
Flight Crew: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Contacted ATC: Yes
Flight Status after Event:
Diversion: Yes
Suggestions*

Deidentified Crewmembers Analyst SSE Report 580

Overview:

Processing:

Status: Closed

ID: 580

Date/Time When Event Occurred: Tue, 27 Nov 2012 17:42 Z

Local Time When Event Occurred: 09:42

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 28 Nov 2012 12:35 Z

Submission Date/Time: Wed, 28 Nov 2012 15:50 Z

Source: Web Submission

Debrief Narrative: SSE event not recorded in log book. No repair/corrective maintenance action recorded

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 125.7

Name of ATC Facility: SMF ATCT

Aircraft Configuration:

Nickname: N57

Tail Number: N57

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: SMF/KSMF - 16R/34L

Narrative:

Initial takeoff from Sacramento CA RWY 16R was aborted at 1742Z (0942 LCL) for a Takeoff Configuration Warning Horn. Apparently, the Spoiler Lever Handle was adjusted ever so slightly beyond the Normal or Arm position for takeoff. However, the Steady Green "Spoiler Arm" as well as the Flashing White "Spoilers Extend" annunciators were both properly illuminated indicating a normal control position for takeoff. The aborted takeoff roll was initiated at slow speed, less than 70 KTS, utilizing the pretakoff briefing. In addition, the Aborted Takeoff Procedure Memory Items were backed up with the checklist depicted on Page E-3 of the Learjet 60 Abnormal Procedures.

Weather at the time was via ATIS Information "F", Wind: Calm, Visibility: 1/8 SM in fog, Ceiling: Indefinite 200, Temp/Dewpoint: 08C/08C, Altimeter Setting: 30.12 IN HG, RWY 16R Touchdown RVR 2,400 FT.

ATC notified of the aborted takeoff roll. A systems check confirmed spoiler lever arm position and a subsequent normal takeoff continued without further incident.

Phase of Flight:

Flight Phase at Start of Event: Takeoff

Cause

Narrative:

Refer to narrative above.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Narrative:
Refer to narrative above.

Deidentified Crewmembers Analyst SSE Report 579

Overview:
Processing:
Status: Closed
ID: 579
Date/Time When Event Occurred: Wed, 21 Nov 2012 21:45 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Thu, 22 Nov 2012 01:01 Z
Submission Date/Time: Thu, 22 Nov 2012 01:01 Z
Source: Web Submission
Debrief Narrative: SWAPPED #1 AND #2 FMS NAV COMPUTERS AND REPROGRAMMED PER T.I 4109.2 34-61-00. FUNCTIONAL CHECK GOOD
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N87
Tail Number: N87
Aircraft Type: CL-601
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:
Just shortly before beginning our briefed descent into PANC after completing Flight inspection work at PAFA the Pilot side PFD displayed a red boxed CDU message and red Boxed FMS1 Message followed shortly by both FMS 's displaying WAAS 1 FAIL and WAAS 2 FAIL messages. The pilot side FMS NAV data then went to all dashes and TCAS Fail message appeared on the #2 pilot side Screen. The pilot reverted to ground based navigation and began the previously briefed decent into PANC. The Co-pilots FMS NAV data was not affected by these anomalies. The weather at the time was VMC. The crew advised ATC of the situation and received a heading vector for PANC. No assistance was requested and the flight continued into PANC without further event.

The pilot-not-flying referred to the QRH however no checklist exists for this situation. This condition lasted approximately 10 minutes then everything appeared to function normally again. This discrepancy was entered into the aircraft discrepancy log.

Phase of Flight:
Flight Phase at Start of Event: Cruise
Cause
Narrative:
After some discussion with our maintenance crew there may have been some problem with the FMS 1 computer. That is purely speculative at this point.
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
How Event Detected:
Self Awareness/Scan: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Contacted ATC: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 576

Overview:

Processing:

Status: Closed

ID: 576

Date/Time When Event Occurred: Fri, 16 Nov 2012 19:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 19 Nov 2012 18:22 Z

Submission Date/Time: Mon, 19 Nov 2012 18:22 Z

Source: Web Submission

Debrief Narrative: SSE event not recorded in log book. No repair/corrective maintenance action recorded

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N57

Tail Number: N57

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Airport: VCV/KVCV - 17/35

Narrative:

Upon post flight inspection bird parts were detected on the right landing gear. Feathers were recovered and sent to the Smithsonian.

No damage was done to the gear and mission was continued.

Phase of Flight:

Flight Phase at Start of Event: Landing

Cause

Narrative:

Bird strike during landing phase.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

PostFlight: Yes

Reaction

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 575

Overview:

Processing:

Status: Closed

ID: 575

Date/Time When Event Occurred: Tue, 13 Nov 2012 15:50 Z

Local Time When Event Occurred: 10:50

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 13 Nov 2012 17:31 Z

Submission Date/Time: Tue, 13 Nov 2012 17:31 Z

Source: Web Submission

Debrief Narrative: FOUND BROKEN WIRE TO #1 FIRE OTTLE,REPAIRED BROKEN WIRE,SYSTEM OPS CHECKED GOOD.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 126.82

Name of ATC Facility: Battle Creek Tower

Aircraft Configuration:

Nickname: N76

Tail Number: N76

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: BTL/KBTL - 05/23

Narrative:

On takeoff roll at approx 60 KIAS, PNF observed discharged light illumination on left fire bottle. PNF called out an abort and PF aborted takeoff. Crew taxied aircraft to hanger with no further incident.

Phase of Flight:

Flight Phase at Start of Event: Rejected Takeoff

Cause

Narrative:

Takeoff roll.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Maintenance: Yes

Corrected Pitch/Power: Yes

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Narrative:

N/A

Deidentified Crewmembers Analyst SSE Report 574

Overview:

Processing:

Status: Closed

ID: 574

Date/Time When Event Occurred: Thu, 08 Nov 2012 15:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 09 Nov 2012 18:13 Z

Submission Date/Time: Fri, 09 Nov 2012 18:13 Z

Source: Web Submission

Debrief Narrative: 11/9/12 Deferred with MEL Number: 75 Found to be the auto-pilot system. (M) procedures C/W by Roger Salinas, RU3A249N, KROC, 11/8/12.

11/9/12 Removed elevator servo and installed repaired elevator servo. Op's check at this time. IAW TI4128.2 Chapt 22.

11/13/12 COULD NOT DUPLICATE DISCREPANCY ON THE GROUND. C/W GOOD AUTOPILOT SYSTEM OPS CHECK AFTER ELEVATOR SERVO REPLACEMENT I.A.W. T.I. 4128.2-1, CHG. 164

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N74

Tail Number: N74

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: RAP/KRAP

Narrative:

Shortly after takeoff crew noticed that with the autopilot engaged that the control yoke seemed catch and then momentarily jolt about the pitch axis causing a minor change in the aircraft pitch attitude. The first occurrence was approximately 1 minute after auto pilot engagement followed by two other events approximately 1 minute apart. After the third occurrence, the autopilot was disengaged and the crew leveled off at approx. 11,500'MSL, contacted ATC and immediately diverted back to Rapid City Regional Airport, South Dakota.

Phase of Flight:

Flight Phase at Start of Event: Initial Climb

Cause

Narrative:

After an inspection was performed by aircraft maintenance a clutch controlling the aircraft pitch malfunctioned. The auto pilot system was then MEL'd.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Overrode Automation: Yes

Took Evasive Action: Yes

Flight Status after Event:

Air Turnback: Yes

Suggestions

Narrative:

None. Ironically the normal preflight check of the auto pilot system was conducted both prior to the flight by the flight crew and then on the ground by aircraft maintenance after the event and no abnormalities were observed.

Deidentified Crewmembers Analyst SSE Report 571

Overview:

Processing:

Status: Closed

ID: 571

Date/Time When Event Occurred: Wed, 31 Oct 2012 15:00 Z

Local Time When Event Occurred: 10:00

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 31 Oct 2012 16:18 Z

Submission Date/Time: Wed, 31 Oct 2012 16:18 Z

Source: Web Submission

Debrief Narrative: DURING DEBRIEF, PILOT NOTED MANUAL EXTEND PUMP HANDLE NOT STOWED: PROPERLY STOWED HANDLE MALFUNCTION DUPLICATED - RESET C/B PERFORMED RETRACTION CHECK 5 TO 7 TIMES. GEAR OP CHECKS GOOD IAW TI 4128.2 CHAPTER 32-30-00

Event: 1

Baseline Risk Assessment

Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: Ardmore Tower
Aircraft Configuration:
Nickname: N79
Tail Number: N79
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Geographic Location:
Airport: KADM - 13/31
Narrative:
ILS 3 at KADM low approach - after low approach raised gear handle and gear did not retract - red light in handle remained illuminated, no three green indication, and landing gear control circuit found to be popped. Tower fly by confirmed mains out and nose gear retracted. On climb out to return to KOKC emergency declared with center and on level off landing gear emergency extension checklist referenced then accomplished. Upon completion of checklist gear indicated down and locked with no other unsafe indications. Landing at KOKC uneventful.
Phase of Flight:
Flight Phase at Start of Event: Go Around
Cause
Narrative:
Because the landing gear relay circuit breaker popped.
Detection
How Event Detected:
Flight Crew: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Declared Emergency with ATC: Yes
Contacted ATC: Yes
Flight Status after Event:
Planned Emergency Landing: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 572

Overview:
Processing:
Status: Closed
ID: 572
Date/Time When Event Occurred: Wed, 31 Oct 2012 14:30 Z
Local Time When Event Occurred: 09:30
Viewer Accessible: Yes
Initial Notification Date/Time: Wed, 31 Oct 2012 20:12 Z
Submission Date/Time: Wed, 31 Oct 2012 20:12 Z
Source: Web Submission
Debrief Narrative: INSPECTED RH ENGINE LWR FWD COWLING DENTED. REMOVED AND REPLACED RH ENGINE LWR FWD COWLING IAW: TI 4128.2 CHAPT 71-10-00
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description

ATC Information:

ATC Radio Frequency (MHz): 123.9

Name of ATC Facility: Des Moines Approach

Aircraft Configuration:

Nickname: N76

Tail Number: N76

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Geographic Location:

Airport: KIKV

Narrative:

While enroute to ILS inspection from KIKV (Ankeny, IA) to KDSM (Des Moines, IA), 2500 MSL, 180 KTS, a flock of small unidentified birds

appeared from above the aircraft and in a downward motion. Aircraft made evasive maneuver upwards and it was believed that no bird strike

occurred. Aircraft was VFR in VMC. All crewmembers agreed that there seemed to be no indication of bird contact. Aircraft proceeded to

ILS inspection. Upon completion of inspection, aircraft landed at KIKV (Ankeny, IA). Preflight for follow-on mission showed signs of bird strike

damage on the right engine air inlet.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Despite evasive maneuvers, bird struck aircraft.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

PreFlight: Yes

Reaction

Flight Crew:

Took Evasive Action: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 573

Overview:

Processing:

Status: Closed

ID: 573

Date/Time When Event Occurred: Mon, 29 Oct 2012 01:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 05 Nov 2012 19:09 Z

Submission Date/Time: Mon, 05 Nov 2012 19:09 Z

Source: Web Submission

Debrief Narrative: Troubleshoot and found faulty NLG downlock sensor #1. Replaced downlock proximity switch IAW TI4109.2, Chpt 32-05-16. Ops check good. Dave Osborne, RU3A249N, NTSU, 1-/29/12 P/N 84-738-709, S/N off F56857, S/N on 01686.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: CTAF

Aircraft Configuration:

Nickname: N86

Tail Number: N86

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Airport: PPG/NSTU - 05/23

Narrative:

On an approx. 4 mile final to NSTU, with the aircraft fully configured for landing, and the before landing checklist complete 2 miles prior to this point, (including three green gear lights and no red lights illuminated) the red light in the gear handle began to flash. Although there were no other unsafe gear indications, the PIC (pilot flying) elected to make a go around, leave the aircraft configured and review the abnormal checklist appropriate to the situation. (Landing Gear/Gear Disagree) After reviewing and complying with the abnormal checklist, as appropriate, to ensure that there was nothing overlooked, and after retarding the power levers to ensure there was no unsafe gear warning horn, discussing the situation amongst all three pilots and maintenance personnel aboard, the decision was made to land the aircraft, and make no changes to aircraft configuration.

A normal landing was made, and the flashing red light in the handle extinguished soon after landing.

Upon inspection, maintenance personnel identified a faulty sensor switch, which was subsequently replaced.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Faulty nose gear sensor switch,

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Executed Go Around: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Narrative:

none

Deidentified Crewmembers Analyst SSE Report 570

Overview:

Other Employees:

Employee Duty: Pilot Monitoring/Pilot Not Flying

First Name: Nolan

Last Name: Crawford

Processing:

Status: Closed

ID: 570

Aware Date/Time: Fri, 26 Oct 2012 19:00 Z

Date/Time When Event Occurred: Fri, 26 Oct 2012 13:50 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 26 Oct 2012 20:03 Z

Submission Date/Time: Fri, 26 Oct 2012 20:03 Z

End of Trip Date/Time: Fri, 26 Oct 2012 17:00 Z

Source: Web Submission

Debrief Narrative: FABRICATED EXTERNAL DOUBLER FROM 2024-T3 .032", ETCHED, ALODINED & PRIMED. RIVETED DOUBLER TO SKIN AT EXTERNAL POWER OUTLET & REPLACED MISSING EXTERNAL POWER OUTLET DOOR.

Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N79
Tail Number: N79
Aircraft Type: BE-300
Flight Crew Employee Information:
Duty On Time: Fri, 26 Oct 2012 12:00 Z
Primary Duties During Time of Event: Pilot
Flight Information:
Departure Airport, Runway and Gate: OKC/KOKC - 17L/35R
Flight Number: FLC79
Scheduled Arrival Airport, Runway and Gate: OKC/KOKC - 17L/35R
Landing Airport, Runway and Gate: OKC/KOKC - 17L/35R
Narrative:
Flight was flown as a training flight from KOKC to KPNC, KF22, KRCE then return KOKC. At some time during the flight the small door the covers the external power receptacle opened and apparently departed the aircraft. It is unknown at what time and at what location the door broke off.
Cause
Narrative:
It is unknown why the door opened and departed the aircraft. It was noted by the SIC and PIC that during the preflight - the door was secured and closed. SIC noted on the sortie prior the door was open during the preflight and that he had to close it. Suspect the door latch became worn allowing the door to unlatch at some point in the sortie and depart the aircraft.
Detection
Reaction
Suggestions

Deidentified Crewmembers Analyst SSE Report 569

Overview:
Processing:
Status: Closed
ID: 569
Date/Time When Event Occurred: Thu, 25 Oct 2012 05:30 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Thu, 25 Oct 2012 12:20 Z
Submission Date/Time: Thu, 25 Oct 2012 12:21 Z
Source: Paper Submission
Debrief Narrative: Inspected all gear uplock assys, wiring harness and adjustment and position of all uplock proximity switches. Found loose target on right MLG uplock. Tightened nut securing target and performed numerous gear retractions and extensions checks IAW TI 4109.2 32-30-00 all ops checks good.
Dave Osborne RU3A249N NZIR 10-25-12 RII Robert Conner. A&P 125 RU3A249N NZIR 10-25-12

Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N86
Tail Number: N86
Aircraft Type: CL-601
Geographic Location:
Airport: NZIR

Narrative:

McMurdo, Antarctica:

Immediately after flight inspection low approach the PF called for gear up. The PNF raised the gear and observed that the flashing red light in the handle did not extinguish. The PF directed the PNF and ACM to reference the appropriate abnormal/emergency checklist. The PNF and ACM (Jumpseat) ran the appropriate checklist and accomplished the directed procedure. The crew landed uneventfully and pinned the landing gear before taxiing to the parking spot without incident.

Cause

Narrative:

-

Detection

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 568

Overview:

Processing:

Status: Closed

ID: 568

Date/Time When Event Occurred: Wed, 24 Oct 2012 21:15 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 25 Oct 2012 12:13 Z

Submission Date/Time: Thu, 25 Oct 2012 12:18 Z

Source: Paper Submission

Debrief Narrative: Found ice buildup on both MLG uplock rollers. Removed ice and lubed rollers and uplocks. Stowed emergency EXT handle and cycled gear 6 times with no faults noted. Operational checks satisfactory IAW TI4109.2, chpt 32-30-00 and 32-35-00.

Work performed by Dave Osborne, RU3A249N, NZIR, 10/25/12. RII

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N86

Tail Number: N86

Aircraft Type: CL-601

Geographic Location:

Airport: NZIR

Narrative:

McMurdo, Antarctica:

Immediately after flight inspection low approach the PF called for gear up. The PNF raised the gear and observed that the flashing red light in the handle did not extinguish. The PF directed the PNF and ACM to reference the appropriate abnormal/emergency checklist. The PNF and ACM (Jumpseat) ran the appropriate checklist and accomplished the directed procedure. The crew landed uneventfully and pinned the landing gear before taxiing to the parking spot without incident.

Cause

Narrative:

-

Detection

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 564

Overview:

Processing:

Status: Closed

ID: 564

Date/Time When Event Occurred: Tue, 16 Oct 2012 15:12 Z

Local Time When Event Occurred: 10:12

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 16 Oct 2012 15:49 Z

Submission Date/Time: Tue, 16 Oct 2012 15:49 Z

Source: Web Submission

Debrief Narrative: RESEATED CONNECTORS ON ENGINE WARNING LIGHT BOX. PERFORMED OP CHECK OF APR SYSTEM IAW TI 4102.2 CHAPTER 76-14-00 PG 201. NO FAULTS NOTED.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 119.35

Name of ATC Facility: Rogers Tower

Aircraft Configuration:

Nickname: N54

Tail Number: N54

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: OKC/KOKC - 13/31

Narrative:

On takeoff when APR was armed, APR activated.

Phase of Flight:

Flight Phase at Start of Event: Rejected Takeoff

Cause

Narrative:

Unknown.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Contacted Company: Yes

Contacted Maintenance: Yes

Flight Status after Event:

Flight Cancellation: Yes

Rejected Takeoff: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 563

Overview:

Processing:

Status: Closed

ID: 563

Date/Time When Event Occurred: Thu, 11 Oct 2012 21:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 15 Oct 2012 17:30 Z

Submission Date/Time: Mon, 15 Oct 2012 17:30 Z

Source: Web Submission

Debrief Narrative: 0/12/12 Deferred with DMI Number: 39 Temporary repair C/W by Steve LaMourea @ Monaco Air Duluth, A&P 2841160, KDLH, 10/12/12

10/15/12 Found no damage on RT outboard stabilizer. Found damage on RT elevator end cap. Removed and replaced end cap as required IAW TI4128.3 Chapt 55

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N74

Tail Number: N74

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Other

Geographic Location:

Airport: DLH/KDLH

Narrative:

During towing/hangaring (pushback) by line service personnel the right outboard tail section strck the wall of the hangar. Crew not onboard aircraft at time of incident.

Phase of Flight:

Flight Phase at Start of Event: Towing

Cause

Narrative:

Unknown. Flight crew not at FBO when incident ocured. Aircraft was towed after crew was off duty.

Detection

How Event Detected:

Maintenance Personnel: Yes

When Event Detected:

PostFlight: Yes

Reaction

Flight Crew:

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Flight Status after Event:

Flight Cancellation: Yes

Flight Delay: Yes

Suggestions

Narrative:

None. Possibly verify that there will be an observer while aircraft being hangared / towed.

Deidentified Crewmembers Analyst SSE Report 562

Overview:

Processing:

Status: Closed

ID: 562

Date/Time When Event Occurred: Sat, 06 Oct 2012 17:30 Z

Local Time When Event Occurred: 13:30

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 09 Oct 2012 13:25 Z

Submission Date/Time: Tue, 09 Oct 2012 13:36 Z

Source: Web Submission

Debrief Narrative: REMOVED AND INSPECTED MAIN OIL FILTER AND RGB CHIP DETECTOR. FOUND FILTER CLEAN, FOUND SMALL DEBRIS (FUZZ) ON CHIP DETECTOR, CLEANED REINSTALLED LEAK AND OPS CHECK FOUND GOOD. REF:TI4128.7-2 CH79.

REINSPECTION REQUIRED AT NEXT 10 FLIGHT HOURS, THAN 50 FLT HOURS. PER PRATT AND WHITNEY ALLOWABLE CATEGORY 2.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: PHL

Aircraft Configuration:

Nickname: N83

Tail Number: N83

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Navigational Aid/VORTAC: WOODSTOWN (OOD) - 81/14.0

Narrative:

Aircrew was conducting a POA on OOD VOR/TAC under IFR in VMC conditions. The R CHIP DETECT Annunciator illuminated in flight. The crew completed the Abnormal Procedures checklist. No secondary engine indications existed. The remainder of the flight inspection was cancelled and the crew diverted to ACY. This Abnormal indication has occurred in the recent past with N83 on the same engine (See the Daily Flight Log dated 7/24/12 for the previous occurrence).

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Unknown events caused this occurrence.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Operated in Degraded Conditions: Yes

Flight Status after Event:

Diversion: Yes

Flight Cancellation: Yes

Suggestions

Narrative:

No suggestions are provided for avoiding a recurrence of this event.

Deidentified Crewmembers Analyst SSE Report 561

Overview:

Processing:

Status: Closed

ID: 561

Date/Time When Event Occurred: Thu, 20 Sep 2012 19:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 20 Sep 2012 20:09 Z

Submission Date/Time: Thu, 20 Sep 2012 20:09 Z

Source: Web Submission

Debrief Narrative: DOWN LOADED MDC AND FOUND THAT BOTH ENGINES HAD REACHED 900C DURING TAKE OFF ROLL. SUSPECT AUTO THROTTLES DID NOT ENGAGE OR THE WRONG DATA WAS INPUT. RED ENGINE WARNING LIGHT SHOULD NOT HAVE ILLUMINATED UNTIL 929C WITH AUTO THROTTLES AND THE CORRECT DATA.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: OKC Tower

Aircraft Configuration:

Nickname: N88

Tail Number: N88

Aircraft Type: CL-604

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: OKC/KOKC - 17R/35L

Narrative:

Rejected takeoff at approximately 100 KIAS.

Phase of Flight:

Flight Phase at Start of Event: Rejected Takeoff

Cause

Narrative:

On takeoff roll, red EICAS "Engine" indication illuminated.

Detection

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

Reaction

Flight Status after Event:

Flight Cancellation: Yes

Rejected Takeoff: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 560

Overview:

Processing:

Status: Closed

ID: 560

Date/Time When Event Occurred: Thu, 13 Sep 2012 02:40 Z

Local Time When Event Occurred: 21:40

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 14 Sep 2012 04:31 Z

Submission Date/Time: Fri, 14 Sep 2012 04:31 Z

Source: Web Submission

Debrief Narrative: Visually inspected radome IAW TI 4128.2 chapter 05-21-02 for evidence of bird strike damage. Also inspected wing root areas + fuselage protrusions. Found bird remains in r/h wing root intake on forward side of cooler. No damage and no further evidence of bird strike noted. Cleaned remains from face of cooler + from cooler intake. This aircraft is approved for return to service with respect to this inspection. Work performed by Carl Thiel A&P 393965875, Maintenance Manager of Landmark Aviation, KUGN, 9/13/12.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:
Risk Factor:
Description
ATC Information:
ATC Radio Frequency (MHz): 118.45
Name of ATC Facility: CTAF
Aircraft Configuration:
Nickname: N74
Tail Number: N74
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Geographic Location:
Airport: LSE/KLSE - 18/36
Narrative:
On 2 mile final approach to Rwy 18, saw flash of a bird and heard "thump." Terminated mission. Upon landing, noted no defects or marks on dark night ramp. During maintenance inspection, found bird remains in air to air exchange inlet on inboard right wing root.
Phase of Flight:
Flight Phase at Start of Event: Approach
Cause
Narrative:
.
Detection
How Event Detected:
Flight Crew: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Executed Go Around: Yes
Flight Status after Event:
No Disruption: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 559

Overview:
Processing:
Status: Closed
ID: 559
Date/Time When Event Occurred: Thu, 30 Aug 2012 19:14 Z
Local Time When Event Occurred: 14:14
Viewer Accessible: Yes
Initial Notification Date/Time: Tue, 04 Sep 2012 14:25 Z
Submission Date/Time: Tue, 04 Sep 2012 14:25 Z
Source: Web Submission
Debrief Narrative: Repaired EVA tube by replacing the ruptured section near the environmental bleed air lines center cabin IAW TI 4128.2 chap 26-11-00. Ran engines, placed environmental switches to on then off no indication of pressure drop. IAW TI 4128.2 chap 26-11-00. Ops check sat.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: OKC APCH
Aircraft Configuration:

Nickname: N79
Tail Number: N79
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Geographic Location:
Airport: OKC/KOKC
Navigational Aid/VORTAC: WILL ROGERS (IRW) - 23/35
Waypoint/Fix: GULLI

Narrative:

While descending through 16,000 feet on the Gulli One Arrival into KOKC, the "LEFT BLEED AIR FAIL" annunciator illuminated. The crew executed the appropriate Bold Face item and completed the BLEED AIR FAIL emergency checklist. An uneventful landing followed at KOKC.

Phase of Flight:

Flight Phase at Start of Event: Descent

Cause

Narrative:

N/A

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 558

Overview:

Processing:

Status: Closed

ID: 558

Date/Time When Event Occurred: Tue, 28 Aug 2012 17:00 Z

Local Time When Event Occurred: 12:00

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 31 Aug 2012 15:59 Z

Submission Date/Time: Fri, 31 Aug 2012 15:59 Z

Source: Web Submission

Debrief Narrative: 8/2/12 Removed and replaced right upper forward wing bolt access panel. IAW TI 4128.3 chapter 20-50-01.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N75

Tail Number: N75

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Airport: KDWH - 17R/35L

Narrative:

Cosmetic wing bolt inspection plate on right wing just outboard engine nacelle began to peel back and tear (remained attached to aircraft). FICO maintenance notified, corrective action taken, and aircraft dispatched under DDL. Resulted in 30 minute delay for PM sortie.

Phase of Flight:

Flight Phase at Start of Event: Arrival Shutdown

Cause

Narrative:

Suspected fastener failed allowing panel to come up during flight.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

PostFlight: Yes

Reaction

Flight Crew:

Contacted Maintenance: Yes

Flight Status after Event:

Flight Delay: Yes

Suggestions

Narrative:

Please refer to Mr Robert Stuckert for history of panel failure.

Deidentified Crewmembers Analyst SSE Report 557

Overview:

Processing:

Status: Closed

ID: 557

Date/Time When Event Occurred: Mon, 27 Aug 2012 15:18 Z

Local Time When Event Occurred: 18:54

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 27 Aug 2012 20:08 Z

Submission Date/Time: Mon, 27 Aug 2012 20:08 Z

Source: Web Submission

Debrief Narrative: Adjusted speed clips and ball studs. Reinstalled panels.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: BHM APCH

Aircraft Configuration:

Nickname: N79

Tail Number: N79

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Airport: BHM/KBHM - 06/24

Narrative:

Arrived vicinity KBHM to commence flight inspection holding patterns for the RWY 06 ILS inspection. There was very little if any turbulence; only an occasional light chop. Without warning, two (2) overhead panels suddenly fell from the cabin ceiling, striking the Mission Specialist. After determining that the Mission Specialist was not injured, returned to KFTY.

Phase of Flight:

Flight Phase at Start of Event: Holding

Cause

Narrative:

Overhead panels not properly attached and secured.

Detection

How Event Detected:

Flight Crew: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Status after Event:
Flight Cancellation: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 556

Overview:
Processing:
Status: Closed
ID: 556
Date/Time When Event Occurred: Mon, 20 Aug 2012 19:00 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Tue, 21 Aug 2012 17:58 Z
Submission Date/Time: Tue, 21 Aug 2012 18:00 Z
Source: Web Submission
Debrief Narrative: RESET ADG AUTO DEPLOY C/B, RESET STALL PROTECTION C/B. PERFORMED SINGLE CHANNEL AND DUAL CHANNEL OPERATIONAL CHECKS SEVERAL TIMES, SYSTEM OP CK GOOD IAW TI 4109,2 CHAP 27-39-00.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: Kansas Center
Aircraft Configuration:
Nickname: N87
Tail Number: N87
Aircraft Type: CL-601
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Geographic Location:
Waypoint/Fix: CNU CHANUTE
Narrative:
En route to an inspection SPS lights betgan to flash. Accomplished checklist and returned to home station.
Phase of Flight:
Flight Phase at Start of Event: Cruise
Cause
Narrative:
SPS circuit breaker was noted out after the checklist was completed
Detection
How Event Detected:
Self Awareness/Scan: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Status after Event:
No Disruption: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 554

Overview:
Processing:

Status: Closed

ID: 554

Date/Time When Event Occurred: Wed, 01 Aug 2012 13:45 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Sat, 04 Aug 2012 13:00 Z

Submission Date/Time: Fri, 10 Aug 2012 15:18 Z

Source: Paper Submission

Debrief Narrative: Accumulator psi was low. Removed and installed new accumulator (see logbook page 119746). Removed and replaced A129 card (time delay card)IAW TI4128.2 39-20-02. Completed gear swing - ops check system.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N77

Tail Number: N77

Aircraft Type: BE-300

Narrative:

Crew noticed that the landing gear relay circuit breaker tripped in flight. Crew used Tripped Circuit Breaker abnormal checklist. Landed without further incident.

Aircraft was issued a Special Flight Permit and was flown with the landing gear extended to KFTY for repair.

Cause

Narrative:

-

Detection

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 553

Overview:

Processing:

Status: Closed

ID: 553

Date/Time When Event Occurred: Tue, 24 Jul 2012 14:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 01 Aug 2012 15:11 Z

Submission Date/Time: Wed, 01 Aug 2012 15:11 Z

Source: Web Submission

Debrief Narrative: -- Inspected right engine chip detector and found small allowable debris IAW TI 4178.7.2. Aircraft OK for service.

Mike Lansing, AP 3336085, Lansing Flight Support, ALB

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: burlington departure

Aircraft Configuration:

Nickname: N83

Tail Number: N83

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

Enroute to KAVP for flight check. Right engine chip detect annunciator illuminated. Followed checklist. All other engine indications were normal. Diverted to KALB for precautionary landing.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

On post flight inspection by mechanic, a small chip was detected on the chip detect plug.

Note: This is the third Chip Detect Light that has occurred on N83 RH Engine since January 2012.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

Reaction

Flight Status after Event:

Precautionary Landing: Yes

Suggestions

Narrative:

N/A

Deidentified Crewmembers Analyst SSE Report 542

Overview:

Processing:

Status: Closed

ID: 542

Date/Time When Event Occurred: Fri, 15 Jun 2012 14:00 Z

Local Time When Event Occurred: 09:00

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 15 Jun 2012 20:11 Z

Submission Date/Time: Fri, 15 Jun 2012 20:11 Z

Source: Web Submission

Debrief Narrative: Follow up 8/29/12 Log sheet # 137025 Corrective Action reads:

Found bird remains in R/H heat exchanger duct. Removed leading edge. Cleaned out bird remains. Inspected heat exchanger, no damage noted at this time/date. Flushed fins with water. Reinstalled leading edge. Ok for return to service. /S/ Tom Thustrom

Signature Technic Air KSTP 6/15/12

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 119.1

Name of ATC Facility: ST. PAUL DOWNTOWN TOWER

Aircraft Configuration:

Nickname: N67

Tail Number: N67

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Airport: STP/KSTP - 14/32

Narrative:

ON INITIAL TAKEOFF, JUST AFTER AIRBORNE, HIT A SMALL BIRD ON RIGHT SIDE OF AIRCRAFT. NOTIFIED TOWER AND RETURNED FOR A FULL-STOP LANDING. POST FLIGHT, NOTED BIRD REMAINS ON LOWER EDGE OF RIGHT AIR-TO-AIR HEAT EXCHANGER INLET.

SNARGE KIT COLLECTED, BIRD REMAINS LOOKED LIKE A BABY HAWK OF SOME KIND.

Phase of Flight:

Flight Phase at Start of Event: Takeoff

Cause

Narrative:

BIRD CROSSED RUNWAY AT THE WRONG TIME.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Flight Status after Event:

Precautionary Landing: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 537

Overview:

Processing:

Status: Closed

ID: 537

Date/Time When Event Occurred: Fri, 18 May 2012 14:15 Z

Local Time When Event Occurred: 10:15

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 18 May 2012 22:00 Z

Submission Date/Time: Mon, 21 May 2012 13:52 Z

Source: Web Submission

Debrief Narrative: Flight Safety Officers will brief this incident to their crewmembers. Dustin Welsh will add it to flight inspection mission training.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 118.45

Name of ATC Facility: Saginaw Approach Control

Aircraft Configuration:

Nickname: N69

Tail Number: N69

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: MBS/KMBS - 05/23

Narrative:

Near Mid-Air Collision.

N69 was operating VFR, conducting an ASR Flight Inspection of MBS, located at KMBS (Saginaw, MI). N69 was being vectored inside the SAGINAW TRSA at 2200 feet for an ASR RWY 23 Approach by the Radar Final Controller on the Final Approach Course using 118.45 MHz. While on the Final Approach Course the previously blank TCAS indicated a close in solid yellow circle target without altitude information while simultaneously alerting "TRAFFIC" in the pilot's headsets. No TCAS RA was received, only a TA.

The Pilot Flying in the left seat disconnected the autopilot while both pilots viewed a Blue and White Cessna 172 between 300 and 400 feet laterally and zero feet vertical separation from our aircraft. The aircraft appeared to be growing in size indicating a converging course. The Pilot Flying took evasive maneuvers to fly under the Cessna. Had those evasive maneuvers not been taken, a

mid-air collision would have occurred. The Cessna did not make any adjustment to its course indicating the pilot likely was unaware of our presence. It is possible that the Cessna was maneuvering for the CLEMENTS (K3CM) Airport traffic pattern.

I immediately reported the Near Mid-Air to the Controller. The Controller was previously unaware of the aircraft and stated that he had his secondary display turned down because he was using primary radar to vector the aircraft on the ASR Approach. He vectored N69 to another downwind to restart the ASR Approach. He later reported that the Cessna was squawking 1300 instead of 1200.

N69 finished the ASR inspection and departed the area.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

See above.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Took Evasive Action: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 536

Overview:

Processing:

Status: Closed

ID: 536

Date/Time When Event Occurred: Wed, 16 May 2012 14:20 Z

Local Time When Event Occurred: 09:20

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 18 May 2012 13:17 Z

Submission Date/Time: Fri, 18 May 2012 13:17 Z

Source: Web Submission

Debrief Narrative: FOUND CROSS THREADED LINE ON NACELLE FUEL COVER. R&R

RH ENG NACELLE FUEL COVER IAW TI 4126.2 CHAP 28-10-00 OP CK&

LEAK CK GOOD

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 124.6

Name of ATC Facility: OKC approach

Aircraft Configuration:

Nickname: N78

Tail Number: N78

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: OKC/KOKC - 17R/35L

Waypoint/Fix: FILUM

Narrative:

Approximately 20 minutes into the flight, while holding awaiting the mission specialists working an AFIS lockup problem, the observer(FAA navajds maintenance engineer) noticed fuel leaking from the oval access panel above the right engine nacelle fuel tank. The leak was not excessive but noticeable and decision was made to land. Upon landing, pilot flying used reverse thrust and the leak increased dramatically. Upon coming out of reverse and beta, leak volume decreased to previous level.

Phase of Flight:

Flight Phase at Start of Event: Holding

Cause

Narrative:

Maintenance was unable to determine the specific source of the leak but did tighten several fuel line connections located underneath the oval access panel. The engine was subsequently run and no leaks were detected.

Detection

How Event Detected:

Passenger: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Status after Event:

Precautionary Landing: Yes

Suggestions

Narrative:

Suggest reducing time interval between inspections of fuel line connections.

Deidentified Crewmembers Analyst SSE Report 535

Overview:

Processing:

Status: Closed

ID: 535

Date/Time When Event Occurred: Tue, 08 May 2012 19:20 Z

Local Time When Event Occurred: 15:20

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 09 May 2012 14:25 Z

Submission Date/Time: Wed, 09 May 2012 14:26 Z

Source: Web Submission

Debrief Narrative: NOTE: The AFIS power down portion of this event was NOT recorded in the aircraft logbook on this date, but the CVR breaker, Spoiler monitor and Trim failure annunciator were. These were deferred by MEL until 5/9/12. The CVR was shorted against some metallic heat shield material, the spoiler monitor was CND and the Trim failure was resolved by replacing the P and CP Flight Control Computer (FCC) cards 850A. See log pages 60121 and 60122 for complete details. In addition, research discovered the L/H generator underwent a time limit change on 5/3/12. A discrepancy "A/C appears to load shed AFIS while taxiing." was entered in the log book on 5/15/12. Repair is recorded as: "Found P745 & P737 on GCP not completely locked, locked same. Found ground stud nut for L/H generator ground on main aircraft ground plate slightly loose. Tightened approx. 1/2 turn. Replaced both L/H and R/H GCU's. DC Generation system Op Checked OK IAW TI 4107.2 24-30-00. Ref also made to TI 4107.2 & TI 4107.5.

Event: 1

Baseline Risk Assessment

Likelihood: Remote

Severity: 1

Risk Factor: Green - Low

Description

Aircraft Configuration:

Nickname: N54

Tail Number: N54

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

During taxi-out AFIS system would power down & come right back up. (3x before take off) Powered entire A/C down & restart/initialize. No other abnormalities noted.

*In flight, CVR breaker tripped, followed @20 mins later by Spoiler Monitor caution light. Spoiler Monitor Abnormal check list procedures followed. Would not reset. Followed shortly thereafter of TRIM failure annunciator. Check list procedures followed. A short time later @15min, AFIS system then again powered itself down and back up.
Flight terminated as A/C was at landing weight.*

Earlier in week left GEN annunciator illuminated off line during flight. Check list procedures followed, GEN reset successfully, and flight (mission) continued.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Possible GEN Load shed issue for unknown reason. Or system spike of electrical system.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Flight Crew: Yes

Reaction

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 534

Overview:

Processing:

Status: Closed

ID: 534

Date/Time When Event Occurred: Mon, 30 Apr 2012 09:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 30 Apr 2012 18:35 Z

Submission Date/Time: Mon, 30 Apr 2012 18:57 Z

Source: Web Submission

Debrief Narrative: Suggestion was added to the BE300PL abnormal checklist. A manual change request was submitted on 11/19/2012 to include this in the legacy BE300 abnormal checklist.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Aircraft Type: BE-300

Narrative:

This is an SIR. See corrective narrative.

Cause

Narrative:

This is an SIR. See corrective narrative.

Detection

Reaction

Suggestions

Narrative:

This is an SIR for inclusion of an Abnormal Procedure addition to our checklist to address failure of a Propeller Ground Idle Stop Solenoid Failure (PROP GND SOL ANNUNCIATOR). These failures are not frequent, but do occur occasionally. Also, it is my subjective

assessment that, lately, there has been an increase in the frequency of these failures. Considering this, I believe a formal checklist addressing appropriate handling of the problem will prevent possibly less effective, "ad-hoc", crew invented solutions and provide the safest handling of the problem.

An old version of the BE300 AFM documented a procedure for FA-226 and after. It is as follows:

PROPELLER GROUND IDLE STOP SOLENOID FAILURE (PROP GND SOL ANNUNCIATOR)

1. PROP GOV TEST Circuit Breaker – PULL
2. PROP GND SOL Annunciator Extinguished – FLY A NORMAL APPROACH. PLAN ON SLIGHTLY LONGER LANDING DISTANCES.

CAUTION

If the PROP GND SOL Annunciator does not extinguish, the pitch of one or both propellers will decrease to the ground idle low pitch stop as power and airspeed are reduced during the approach and landing, causing an increase in drag and possible yawing of the airplane.

3. PROP GND SOL Annunciator illuminated – FLY A SHALLOW, POWER ON APPROACH AT 1450 RPM. DO NOT REDUCE POWER UNTIL IN THE FLARE. PLAN ON SLIGHTLY LONGER LANDING DISTANCES.

I request that the above procedure, or another suitable one be developed and included in our Company AFM and checklist.

Thank you.

Deidentified Crewmembers Analyst SSE Report 532

Overview:

Processing:

Status: Closed

ID: 532

Date/Time When Event Occurred: Thu, 26 Apr 2012 16:25 Z

Local Time When Event Occurred: 11:25

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 26 Apr 2012 19:28 Z

Submission Date/Time: Thu, 26 Apr 2012 19:28 Z

Source: Web Submission

Debrief Narrative: SERVICED RT ENGINE WITH OIL IAW TI4128.2 CH. 12 ENGINE RUN UP ALL INDICATION CHECKED NORMAL. NO OIL LEAKS FOUND. Aircraft landed without incident; No Service Difficulty Reoprt filed.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 118.5

Name of ATC Facility: ADM Tower

Aircraft Configuration:

Nickname: N79

Tail Number: N79

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: KADM - 13/31

Narrative:

On final for RWY 31 at KADM, crew noticed #1 oil pressure on EIS was YELLOW. #1 engine was 36% torque, 88% rpm, 83 psi oil press. Consulted POH emergency section, elected to full stop at KADM.

Landing uneventful. While taxiing in, #1 oil pressure on EIS turned RED. Engine in idle, oil pressure was 45 psi. Shutdown #1 engine taxiing in, according to POH. Shutdown normal.

On post flight, #1 engine dipstick was clean, no oil. #2 engine dipstick showed 2 quarts low. Oil film observed on gear doors on #1 nacelle.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Appears #1 engine was running out of oil, possible slow leak.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Engine Shutdown: Yes

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 533

Overview:

Processing:

Status: Closed

ID: 533

Date/Time When Event Occurred: Thu, 26 Apr 2012 16:00 Z

Local Time When Event Occurred: 09:00

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 26 Apr 2012 21:16 Z

Submission Date/Time: Thu, 26 Apr 2012 21:16 Z

Source: Web Submission

Debrief Narrative: R&R tire assy IAW Ti 4107.2 chap 32-40-01. Sys check good.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: LGB Tower

Aircraft Configuration:

Nickname: N57

Tail Number: N57

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: LGB/KLGB - 12/30

Narrative:

Upon initial takeoff roll out of KLGB, all three crew members felt a severe nosewheel vibration at approximately 130 KIAS shortly after V1 and just prior to rotation (V1=128kts Vr =137kts). This continued during climbout with gear extended for over a minute. Crew suspected a possible nose tire failure or nose gear malfunction due to the severity of the vibration and noise. Gear was left extended

and crew elected to fly a low approach back at KLGB for a visual check of nose gear by KLGB ATCT. Tower advised that nose gear "appeared normal" and crew asked that the runway be checked for possible debris. No debris was found. Aircraft was flown back to SMF with landing gear extended to burn down fuel, run applicable checklists, and coordinate for potential nose wheel failure upon landing. (Contact crew for expanded explanation of courses of action taken and considerations made as they are too extensive to include in this SSE format). An emergency was declared and emergency response vehicles were requested to be standing by. A low approach for another visual inspection was also made at KSMF. Aircraft landed uneventfully with no abnormal nose wheel indications during landing rollout. A visual inspection of nose gear was made upon clearing runway prior to taxiing back to ramp. SAC FIFO MX inspected nose wheel assembly and found no discrepancies that could have caused such a severe vibration.

Phase of Flight:

Flight Phase at Start of Event: Takeoff

Cause

Narrative:

Possible cause may have been contact with a runway centerline light just as weight was being taken off of nose wheel causing an oscillation frequency that led to an excessively severe vibration to the nose wheel and nose gear assembly. This is best guess speculation only based on current information.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Exercised Captain Emergency Authority: Yes

Declared Emergency with ATC: Yes

Landed in Emergency Condition: Yes

Contacted ATC: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Corrected Pitch/Power: Yes

Flight Status after Event:

Unplanned Emergency Landing: Yes

Diversion: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 531

Overview:

Processing:

Status: Closed

ID: 531

Date/Time When Event Occurred: Thu, 19 Apr 2012 19:30 Z

Local Time When Event Occurred: 15:30

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 20 Apr 2012 14:02 Z

Submission Date/Time: Fri, 20 Apr 2012 14:02 Z

Source: Web Submission

Debrief Narrative: REPAIRED TUBING INSIDE LT NACELLE OPES CHECK OF BLEED AIR FAIL WARNING CHECKED GOOD. REPAIR REFERENCE COMMUNIQUE 1989-56. There was FOM previously accomplished for a bird strike, however there is no evidence that this event was related to the bird strike.

Event: 1

Baseline Risk Assessment

Likelihood: Probable

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: ATLANTA

Aircraft Configuration:

Nickname: N80
Tail Number: N80
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Geographic Location:
Airport: CAE/KCAE
Narrative:
ENROUTE TO KFTY AT FLIGHT LEVEL 180, RIGHT BLEED AIR FAIL LIGHT ILLUMINATED. COMPLETED BOLD FACE MEMORY ITEMS AND BACKED UP WITH EMERGENCY CHECKLIST. FLIGHT CONTINUED. LANDING AT KFTY WAS EVENTFUL.
Phase of Flight:
Flight Phase at Start of Event: Cruise
Cause
Narrative:
AIRCRAFT PART/SYSTEM FAILURE.
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Status after Event:
No Disruption: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 527

Overview:
Processing:
Status: Closed
ID: 527
Date/Time When Event Occurred: Thu, 12 Apr 2012 19:00 Z
Local Time When Event Occurred: 14:00
Viewer Accessible: Yes
Initial Notification Date/Time: Thu, 12 Apr 2012 20:05 Z
Submission Date/Time: Thu, 12 Apr 2012 20:05 Z
Source: Web Submission
Debrief Narrative: EVA MELT THRU AT FIRST FORMER PAST THRU FROM "T" JUNCTION GOING FWD ON LT SIDE NACELLE. REPLACED ENTIRE EVA LENGTH FROM "T" FITTING TO END PLUG. CHECKED "Y" CONNECT BLEED AIR BOOTS AND TIGHTENED LOOSE CLAMPS. REINSULATED AND FOIL WRAPED. OPS CHECKED GOOD.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N80
Tail Number: N80
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Geographic Location:
Waypoint/Fix: SQS SIDON
Narrative:
During climb out at approximately FL200, the right BL FAIL light illuminated. The EMERGENCY Procedures checklist was referenced for corrective action. Crew diverted to home station (KFTY) for repair. During decent through 14,500 ft. the light extinguished.
Phase of Flight:

Flight Phase at Start of Event: Climb

Cause

Narrative:

right BL FAIL light illuminated.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Contacted Operations: Yes

Flight Status after Event:

Diversion: Yes

Suggestions

Narrative:

N/A

Deidentified Crewmembers Analyst SSE Report 526

Overview:

Processing:

Status: Closed

ID: 526

Date/Time When Event Occurred: Wed, 11 Apr 2012 20:00 Z

Local Time When Event Occurred: 15:00

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 12 Apr 2012 14:26 Z

Submission Date/Time: Thu, 12 Apr 2012 14:30 Z

Source: Web Submission

Debrief Narrative: Removed bird feathers and remains from left prop. Performed visual inspection of left prop, left spinner, wing leading edge. No damage noted. Removed top forward cowl and intake access, visually inspected top of engine and intake screens for bird strike damage. No bird strike damage or defects noted IAW Standard Airframe Practices B300 Maintenance manual 20-00 /S/ Dale Perry, 4/12/2012, West Star Aviation KSUS CRS# PAZR068H.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N81

Tail Number: N81

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Airport: KMWA - 11/29

Narrative:

During Commissioning Check of RWY 29 APL/P, aircraft was on 50 foot low approach. At approximately half way down the runway, a lone, small, dark colored bird was observed trying to miss the aircraft and flew down the left side of the fuselage. Shortly afterwards, pilot flying in left seat noticed blood splatter on top of left engine cowling. No effect on aircraft controllability or engine instruments was noted. Tested Prop De-Ice and Wing De-Ice Boots with no defects found. Relayed information to FICO via ground maintenance personnel who directed aircraft to divert to KSUS for maintenance inspection. Upon landing at KSUS, it was determined that the bird impacted a prop on the left engine. Blood and organic matter was splattered on the engine cowling, left side of the fuselage, inboard leading edge of the left wing and two feathers were found in the left oil cooler intake. Feathers were collected for SNARGE submission. Aircraft was inspected, cleaned and returned to service.

Phase of Flight:
Flight Phase at Start of Event: Approach
Cause
Narrative:
Unavoidable hazard of low flying aircraft.
Detection
How Event Detected:
Flight Crew: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Contacted ATC: Yes
Contacted Operations: Yes
Flight Status after Event:
Diversion: Yes
Suggestions
Narrative:
None.

Deidentified Crewmembers Analyst SSE Report 528

Overview:
Processing:
Status: Closed
ID: 528
Date/Time When Event Occurred: Tue, 10 Apr 2012 16:30 Z
Local Time When Event Occurred: 11:30
Viewer Accessible: Yes
Initial Notification Date/Time: Mon, 16 Apr 2012 14:35 Z
Submission Date/Time: Mon, 16 Apr 2012 14:35 Z
Source: Web Submission
Debrief Narrative: STEAMED CLEANED SIDEWALL PANELS, SEATS & INTERIOR PANELS AS REQUIRED . NOTE: There was no refrigerant conversion taking place, however, there was a total baseline reserivcing as per a MAD issued to baseline the system for previous A/C problems..
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N73
Tail Number: N73
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Geographic Location:
Airport: KEFD
Narrative:
During preflight, the crew noticed a strong smell of what they thought was a santizer or air freshner. We manned the aircraft anticipating the smell would dissipate. Approximately 2 hours into the flight, the smell had the effect of becoming stronger and was becoming irritating. Causing throat and chest irritation, nausea, and headache and slight dizziness. During flight inspection at low altitudes, cabin dump selection appeared to lessen the intensity of the odor for the short periods that it was used. After landing at Ellington Field, Houston, Tx. the lineman commented about the strong odor coming from the aircraft cabin while he was standing at the airstair door. At that point, the aircrew became concerned that the odor may not have been an air freshner. The PIC immediately call FICO maintenance and explain the situation. At FICO's recommendation, we called MEDAIR. MEDAIR doctor recommended us to

call poison control. Poison control recommended a chest Xray for Mr. Turner, who's symptom were a persistent cough and slight chest congestion. The Xray results were unremarkable.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

FICO maintenance explained that the King Air 300 fleet was changing there air conditoning freon from R12 to R134. During the refrigerant flush, approxiatelly 6 oz of flushing solvent, terpene hydrocarbon, was spilled under the cabin floor on the main airconditioner aft evaporator blower. Harco Aviation maintenance manager, at Ellington Field, showed us that both cabin filters were contaminated by a yellow substance with a strong chemical odor. The terpene hydrocarbon is listed as a hazardous substance on the material safety data sheet.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Maintenance: Yes

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Narrative:

EOSH be involved in aircraft chemical spills and any other hazards that may go unreported. A process should be put in place to allow maintenance personnel to report hazards of this nature without fear of reprisal. Accountability is vital for any QA process and this incident gives the appearance that there is no accountability for the Maintenance QA process.

Deidentified Crewmembers Analyst SSE Report 524

Overview:

Processing:

Status: Closed

ID: 524

Date/Time When Event Occurred: Mon, 02 Apr 2012 21:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 04 Apr 2012 17:47 Z

Submission Date/Time: Wed, 04 Apr 2012 17:47 Z

Source: Web Submission

Debrief Narrative: Could not duplicate defect, changed NLG #2 downlock switch per instructions. Ops check C/W per TI 4109.2 32-60-61 and 32-30-00

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N86

Tail Number: N86

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: SCC/PASC - 04/22

Narrative:

On climb out, red flashing lights in gear handle wold not extinguish. followed checklist on page E43, fly to PANC at reduced speed and landed.

Phase of Flight:

Flight Phase at Start of Event: Takeoff

Cause

Narrative:

Microswicth/proximity failure

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Operated in Degraded Conditions: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 523

Overview:

Processing:

Status: Closed

ID: 523

Date/Time When Event Occurred: Thu, 22 Mar 2012 19:30 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 30 Mar 2012 18:21 Z

Submission Date/Time: Fri, 30 Mar 2012 18:26 Z

Source: Paper Submission

Debrief Narrative: FOUND R/H PROPELLER REVERSE CLEVIS PIVOT BOLT BOTTOMED OUT ON FWD EDGE OF REV CLEVIS. ADJUSTED REVERSE CABLE FWD AND AFT BALL STOPS, CLEVIS, TORQUE SET SCREW, GROUND STOP SOLENOID BRACKET AND PLUNGER ADJUSTMENT, NF LINK GAP, PERFORMED GRND RUNS, FOUND FLT IDLE TORQUE AND ALL PARAMETERS GOOD. REF TI4128.2 CH 76 AND 61.

RII

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N71

Tail Number: N71

Aircraft Type: BE-300

Geographic Location:

Airport: BWI/KBWI - 15L/33R

Narrative:

On final approach into runway 15L at KBWI for a full stop landing, before landing checklist completed, right prop pitch light illuminated with a simultaneous right yaw of the airplane at approximately 20 feet above the ground. Directional control of the airplane was maintained with rudder and a go-around was initiated. The situation was discussed by the crew and it was decided to land the airplane with prop RPM at 1500. No further discrepancies were observed during remainder of flight.

Phase of Flight:

Flight Phase at Start of Event: Landing Flare

Cause

Narrative:

-

Detection

How Event Detected:

Flight Crew: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Executed Go Around: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 520

Overview:
Processing:
Status: Closed
ID: 520
Date/Time When Event Occurred: Thu, 15 Mar 2012 19:00 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Thu, 15 Mar 2012 23:46 Z
Submission Date/Time: Thu, 15 Mar 2012 23:46 Z
Source: Web Submission

Debrief Narrative: Left engine upper cowl and prop spinner were not reinstalled. At this time the aircraft has been found to be unairworthy and is not approved for return to service. Work performed by Colgan Air Service.; CONTINUED ON LP 128059 by FAA Maintenance: Inspected left prop and engine after bird strike per TI 4128.7-2 section 12 L, Note 2 no prop strike occurred. Inspected engine exhaust flange for damage, no damage noted, engine run completed no defects noted. Work performed RU3A796U, 3/19/12, RII accomplished.; Removed #1 engine upper nose cowl and propeller spinner. Identified engine and prop models. Assessed damage of bird strike into left prop spinner, propeller, upper nose cowling and inboard No. 1 exhaust stack. Damage noted: small dent to prop spinner, prop blade de-ice boot torn, damage to blade underneath boot is unknown. Extensive damage to inboard exhaust stack and upper nose cowling. As per Pratt & Whitney PT6-60A maintenance Manual part # 3034342, 72-00-00 page 638, paragraph 1.(1) for prop sudden stoppage, prop strike causing blade structural damage (eg bent blade or blade tip missing or bent over 1 inch (over 5 inches for composite props) prop strike on a power line, or a prop strike at a power setting above flight idle (Ng above 82%) do the following: Paragraph (l) a: remove power section and send to authorized Pratt & Whitney Service facility for light overhaul, and comply with inspections IAW paragraph L(1) b 1-9.

Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: La Crosse, WI
Aircraft Configuration:
Nickname: N74
Tail Number: N74
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying

Narrative:
On climb out after conducting an ILS-3 at KLSE RWY 18 we were climbing at approx 1500FPM in a left turn and suddenly noticed a large area of eagles soaring in our flight path. Due to the short time between visually seeing the birds little evasive action was taken due to our climb rate and the position of the birds. Both pilots tucked behind the instrument panel momentarily to avoid possible injury. The impact was heard by all crew members and we immediately noticed extensive damage to the area on the inside on the #1 engine nacelle and a severely deformed exhaust stack. Flight crew conducted a flight control check prior to landing due to the possibility of other areas of the aircraft being damaged that we could not see.

Phase of Flight:
Flight Phase at Start of Event: Climb
Cause

Narrative:
Numerous: Warm weather, spring time, open water, and migrating birds. We were climbing and birds normally descend as an aircraft approaches which left us virtually no options to avoid the birds.

Detection

How Event Detected:

Flight Crew: Yes

Other Aircraft/Pilot: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

PostFlight: Yes

Reaction

Flight Crew:

Landed in Emergency Condition: Yes

Contacted ATC: Yes

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Operated in Degraded Conditions: Yes

Overrode Automation: Yes

Took Evasive Action: Yes

Flight Status after Event:

Precautionary Landing: Yes

Diversion: Yes

Suggestions

Narrative:

Numerous birds were being reported by ATC and observed by the flight crew. The only suggestion would be to not flight check in areas that include large flocks of birds.

Deidentified Crewmembers Analyst SSE Report 519

Overview:

Processing:

Status: Closed

ID: 519

Date/Time When Event Occurred: Wed, 14 Mar 2012 07:36 Z

Local Time When Event Occurred: 01:36

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 14 Mar 2012 13:50 Z

Submission Date/Time: Wed, 14 Mar 2012 13:50 Z

Source: Web Submission

Debrief Narrative: Deferred with DMI Number: 80: A SFP has been issued for a one-time flight from APA to OKC.: T/S/SYSTEM AND FOUND NOSE DOWN LOCK MICRO SWITCH WITH SEVERAL BROKEN WIRES AT SWITCH, REMOVED, REPLACED, RIGGED AND OPS CHECKED NOSE GEAR DOWN LOCK MICRO SWITCH IAW T.I.4109.2 CHAP 32-30-00 AND CHAP 32-60-00. CYCLIED GEAR SEVEN TIMES, OPS CHECKED GOOD EACH TIME.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N87

Tail Number: N87

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: KAPA - 17L/35R

Narrative:

On a 7 mile final at 7300MSL (1500'agl) landing gear was selected down at approximately 180KIAS and flaps at 20 deg. MLG's extended normally, Nose gear door light remained illuminated, light in the gear handle extinguished, and NLG gear light remained extinguished. Intermittently heard a loud grinding sound and felt a vibration, accompanied by very dim flickering of the NLG green light and intermittent flashing of master caution and antiskid annunciator. Coordinated with tower to carry thru the airfield at 7300 MSL and returned to approach control. Set up a hold to the east of the field to consult emergency//abnormal checklists. Verified the NLG was not down by selecting full flaps to get warning horn and testing lights. After an estimated 12-15 minutes, the NLG extension cycle completed normally without any crew action (gear handle was never actuated after the initial extension attempt and no manual gear extension attempted). Uneventful landing followed.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Mechanical malfunction

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Executed Go Around: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 515

Overview:

Processing:

Status: Closed

ID: 515

Date/Time When Event Occurred: Wed, 29 Feb 2012 15:20 Z

Local Time When Event Occurred: 09:20

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 29 Feb 2012 15:58 Z

Submission Date/Time: Wed, 29 Feb 2012 15:58 Z

Source: Web Submission

Debrief Narrative: REMOVED AND INSPECTED ALL LATCHES AND RE-SECURED COWLING. IAW TI4128.2 CHAPTER 71-10-00. Human Factors investigation initiated 3/5/12

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 124.2

Name of ATC Facility: OKC Departure

Aircraft Configuration:

Nickname: N67

Tail Number: N67

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: OKC/KOKC - 17R/35L

Narrative:

After departure from RWY 35L at KOKC during the initial climb, the MS noticed an unusual gap at the top of the left engine cowling. MS notified the flight crew. PF/PNF concurred that this was an unusual situation and the PF instructed the PNF to contact OKC Departure for a return to the airfield. PNF coordinated a return to the traffic pattern but DID NOT declare an emergency with ATC. During maneuvering to 35L, PNF asked PF if he wanted a return to RWY 31 which the aircraft was aligned with at the time and a runway with a more direct headwind (reported winds 290@11). Approach and landing made with no further complications.

Phase of Flight:

Flight Phase at Start of Event: Initial Climb

Cause

Narrative:

During the preflight, there was no indication that the left engine's outboard aft engine cowling latch was not locked properly. Alignment marks showed good, though this particular latch is hard to see due to soot accumulated. Once airborne, the airflow and the vibration obviously caused a gap to form. Once on the deck, it was discovered that the latch was loose to the touch and even when the latch showed closed, just pushing on the cowling would move the indicator.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Flight Status after Event:

Precautionary Landing: Yes

Suggestions

Narrative:

Overall, engine cowling latch indicators should be cleaned of soot to enable easy identification of latch positioning. This latch in particular (N67, left engine, outboard, aft) need to be painted for easier identification.

Deidentified Crewmembers Analyst SSE Report 511

Overview:

Processing:

Status: Closed

ID: 511

Date/Time When Event Occurred: Thu, 23 Feb 2012 16:06 Z

Local Time When Event Occurred: 11:06

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 23 Feb 2012 21:41 Z

Submission Date/Time: Thu, 23 Feb 2012 21:41 Z

Source: Web Submission

Debrief Narrative: Removed removed floor panel nose section avionics bay. Removed and replaced expansion valve and 33 degree switch. Installed floor panel Ran Engines and pressurized aircraft ops check good ref T.I. 4128.2 chapter 2100

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N77

Tail Number: N77

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Other

Geographic Location:

Airport: ILM/KILM

Narrative:

While conducting flight inspection at KEWN, crew noticed that the air conditioning was no longer cooling. Cockpit temperature quickly increased to 89 degrees. Crew completed the final three ILS-2. We departed the area enroute to KILM. Where FICO Maintenance coordinated aircraft support. It was discovered that the air compressor appeared to have seized. This caused the drive belt to fray and melt to the compressor. Aircraft received an MEL, and returned to (KFTY) home base.

Phase of Flight:

Flight Phase at Start of Event: Non-Flight

Cause

Narrative:

N/A

Detection

How Event Detected:

Maintenance Personnel: Yes

When Event Detected:

PostFlight: Yes

Reaction

Flight Crew:

Contacted Maintenance: Yes

Contacted Operations: Yes

Suggestions

Narrative:

N/A

Deidentified Crewmembers Analyst SSE Report 514

Overview:

Processing:

Status: Closed

ID: 514

Date/Time When Event Occurred: Thu, 23 Feb 2012 15:35 Z

Local Time When Event Occurred: 09:35

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 27 Feb 2012 16:54 Z

Submission Date/Time: Tue, 28 Feb 2012 16:08 Z

Source: Web Submission

Debrief Narrative: PROBLEM CORRECTED ITSELF BEFORE LANDING, COULD NOT DUPLICATE PROBLEM ON THE GROUND, NO FAULTS NOTED ON DIAGNOSTIC PAGES. CHECKED IAPS CARD CAGE CANNON PLUGS, REMOVED IOC CARDS, INSPECTED CONNECTORS AND X-ROLLED IOC CARDS. REMOVED FMS #1 AND #2 NCU'S, INSPECTED AND CLEANED CONNECTORS AND RESEATED NCU'S. RAN SYSTEM FOR OVER AN HOUR, CHECKED MAP FUNCTIONS WITH FLIGHT PLAN, CHECKED DIAGNOSTIC PAGES WITH NO FAULTS, SYS OP CHECK SAT IAW TI 4109.2-2 CH 34-61-00 AND 34-22-21.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: Memphis ARTCC

Aircraft Configuration:

Nickname: N87

Tail Number: N87

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

In cruise flight at 17000 between Benton/Saline County Regional, AR (KSUZ), and Houston Memorial, MO (M48), received FMS warning messages of WAAS #1 and WAAS #2 fail on both FMSs. A review of the sensor pages on both FMS showed dashed lines for both WAAS #1 and WAAS #2. Simultaneously received CDU Fail and FMS Fail warning flags on pilots PFD, and loss of navigation capability on the pilots side. MAP and Radar Cntl Fail warning flags also appeared on pilots MFD. Transferred navigation of the

aircraft over to the right side. Attempted to switch away from the FMS as a navigation source on the pilot side but were unsuccessful. Advised Memphis Center we had a problem on the aircraft but were not declaring an emergency at that time and diverted to home station (KOKC), remaining in VFR conditions. After approximately twenty-five minutes of no navigation capability on the pilot side all warning and failure flags cleared on their own.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Unknown.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Contacted Company: Yes

Operated in Degraded Conditions: Yes

Flight Status after Event:

Diversion-Other Alternate: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 513

Overview:

Processing:

Status: Closed

ID: 513

Date/Time When Event Occurred: Tue, 21 Feb 2012 16:50 Z

Local Time When Event Occurred: 11:50

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 27 Feb 2012 14:56 Z

Submission Date/Time: Mon, 27 Feb 2012 14:56 Z

Source: Web Submission

Debrief Narrative: ACCESSED BACK SIDE OF DENT AND REMOVED IAW T.I. 4125.3 SECTION 20-10-03

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N74

Tail Number: N74

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: HUF/KHUF - 05/23

Narrative:

While conducting a 50 foot run during a commissioning inspection of the KHUF VASI, Runway 23, a flock of approximately 100 small black birds located approximately half way down the runway departed the ground due to the noise of the approaching aircraft. The birds flew into the path of the aircraft. The pilot flying adjusted the flight path attempting to miss the birds.

Aircraft struck at least one bird on the heated engine intake of the number one engine. Dent on intake was found on post flight inspection. Bird appeared to have struck intake and deflected outboard striking left wing, just outboard of the engine, leaving trail of

blood. No apparent damage noted on left wing. No other evidence of recent bird impacts were noted during the post flight inspection.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

See event narrative.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Maintenance: Yes

Contacted Operations: Yes

Took Evasive Action: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 510

Overview:

Processing:

Status: Closed

ID: 510

Date/Time When Event Occurred: Wed, 15 Feb 2012 17:00 Z

Local Time When Event Occurred: 11:00

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 15 Feb 2012 20:12 Z

Submission Date/Time: Wed, 15 Feb 2012 20:12 Z

Source: Web Submission

Debrief Narrative: REACTIVATED T/R IAW T.I.4109.2 CHAP 78-30-00, T/R OPS CHECKED GOOD WITH SHOP AIR SEVERAL TIMES WITH NO FAULT FOUND IAW T.I.4109.2 CHAP 78-30-00, CLEANED AND LUBRICATED PNEUMATIC DRIVE/FLEXSHAFT LOCK UNIT IAW T.I.4109.2 CHAP 78-30-46. RIGHT T/R OPS CHECKED GOOD.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: msp

Aircraft Configuration:

Nickname: N87

Tail Number: N87

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Waypoint/Fix: WAVEY

Narrative:

FL 150 right TR unlock light, crew pressed TR Emergency Stow and complied with all appropriate checklists. Declared Emergency with MSP Center and diverted to Nearest airport with adequate runway length. KDSM

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:
Event occurred because of TR malfunction
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Declared Emergency with ATC: Yes
Landed in Emergency Condition: Yes
Flight Status after Event:
Unplanned Emergency Landing: Yes
Diversion-Other Alternate: Yes
Suggestions
Narrative:
NA

Deidentified Crewmembers Analyst SSE Report 512

Overview:
Processing:
Status: Closed
ID: 512
Date/Time When Event Occurred: Wed, 08 Feb 2012 18:35 Z
Local Time When Event Occurred: 10:35
Viewer Accessible: Yes
Initial Notification Date/Time: Thu, 23 Feb 2012 22:23 Z
Submission Date/Time: Thu, 23 Feb 2012 22:23 Z
Source: Web Submission
Debrief Narrative: Reseated all IAPS cards, reseated all IAPS cannon plugs. Verified all feed through connectors in E&E bay were secure. maintenance diagnostic page indicates no failures. All avionics good IAW TI 4109.2-1 Chapter 34.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: SEA ARTCC
Aircraft Configuration:
Nickname: N87
Tail Number: N87
Aircraft Type: CL-601
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Narrative:
On the descent into Spokane, Washington, leaving 17000 for 13000, numerous primary flight display (pfd) and navigation display (nd) flags appeared on pilots and copilots sides. After reaffirming primary flight control instrumentation usability/capability, we determined that we lost all RNAV capability but attitude/pitot-static (acft control) again were ok. During troubleshooting the following errors were displayed on copilots nd that were not present on pilots nd were rdr fault, fault and Inav/ vnav flags, with fms messages of waas 1/2 fail, and sensor mis-compare.
Pilot flying switched to raw data, and after approx 5 minutes all errors were removed from view with normal op. However, we remained raw data for the rest of the descent and landing.

The malfunction was discussed with AVN maintenance on the ground, and written up. No discrepancies found .
Phase of Flight:

Flight Phase at Start of Event: Descent
Cause
Narrative:
Unknown.
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
How Event Detected:
Flight Crew: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Operated in Degraded Conditions: Yes
Override Automation: Yes
Flight Status after Event:
Flight Cancellation: Yes
Flight Delay: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 509

Overview:
Processing:
Status: Closed
ID: 509
Date/Time When Event Occurred: Sat, 04 Feb 2012 00:40 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Tue, 07 Feb 2012 12:04 Z
Submission Date/Time: Tue, 07 Feb 2012 12:04 Z
Source: Web Submission
Debrief Narrative: This was a loose Fuel Cap in Flight and no Mx entry was made. The Pre-Flight checklist requires the crew to ensure the fuel cap is secure. No Maintenance entry was made.

Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: Cleveland Center
Aircraft Configuration:
Nickname: N74
Tail Number: N74
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Geographic Location:
Airport: MBS/KMBS
Narrative:
After night time refueling at KTVC, a normal takeoff and climb occurred. Upon reaching FL200 enroute to KDTW it was observed by the pilot flying that fuel was streaming from the left outboard fuel cap. After confirmation by both the PNF (PIC) and MS an emergency was declared and a normal landing was made at KMBS.
Phase of Flight:
Flight Phase at Start of Event: Cruise
Cause
Narrative:

It appears that the refueler pinched the lanyard from the fuel cap in the seal on the top of the tank. Unfortunately there are no visible cues from outside of the aircraft (fuelcap) that would indicate if / when the lanyard is pinched in the seal of the tank.

Detection

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Exercised Captain Emergency Authority: Yes

Declared Emergency with ATC: Yes

Landed in Emergency Condition: Yes

Contacted ATC: Yes

Executed Emergency Descent: Yes

Flight Status after Event:

Precautionary Landing: Yes

Diversion-Filed Alternate: Yes

Flight Cancellation: Yes

Planned Emergency Landing: Yes

Suggestions

Narrative:

None other than removing and visually inspecting each fuel cap after EVERY refueling. A possible solution might be to ask the refueler to exercise extra caution with the lanyard(s) when replacing the fuel cap(s) after refueling.

Deidentified Crewmembers Analyst SSE Report 507

Overview:

Processing:

Status: Closed

ID: 507

Date/Time When Event Occurred: Wed, 25 Jan 2012 19:24 Z

Local Time When Event Occurred: 10:24

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 26 Jan 2012 14:37 Z

Submission Date/Time: Thu, 26 Jan 2012 17:02 Z

Source: Web Submission

Debrief Narrative: Repl. R/H ground spoiler prox switch. Ops check good IAW 4109.2 27-61-00

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

ATC Radio Frequency (MHz): 118.3

Name of ATC Facility: ANC ATCT

Aircraft Configuration:

Nickname: N85

Tail Number: N85

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Geographic Location:

Airport: ANC/PANC - 14/32

Narrative:

PRIOR TO TAXI FROM ANC FIFO RAMP, RIGHT HAND GROUND SPOILER EXTENDED ANNUNCIATOR ILLUMINATED. AIRCRAFT REFERRED TO MAINTENANCE PERSONNEL. GROUND SPOILER SYSTEM DEFERRED IAW AIRCRAFT MANUAL MEL (27-67-01). GROUND SPOILER SYSTEM TO BE SELECTED TO THE "OFF" POSITION PRIOR TO TAKEOFF.

CREW COMPLIED WITH MEL AND SELECTED THE GROUND SPOILER SYSTEM TO THE "OFF" POSITION AND RECALCULATED TAKEOFF FIELD LENGTH. AT INITIAL THRUST LEVER ADVANCEMENT ON TAKEOFF ROLL, THE TAKEOFF CONFIGURATION WARNING HORN SOUNDED AND THE TAKEOFF WAS ABORTED. ATCT WAS NOTIFIED. AIRCRAFT TAKEOFF CONFIGURATION WAS AGAIN REVIEWED BY THE CREW WITHOUT ANY DISCREPANCIES NOTED. AIRCRAFT TAXIIED BACK TO THE ANC FIFO FOR FURTHER REVIEW BY MAINTENANCE PERSONNEL.

Phase of Flight:

Flight Phase at Start of Event: Takeoff

Cause

Narrative:

MAINTENANCE PERSONNEL IDENTIFIED AND REPLACED A FAULTY RIGHT HAND GROUND SPOILER SYSTEM PROXIMITY SWITCH. BOTH THE GROUND SPOILER SYSTEM AS WELL AS THE TAKEOFF CONFIGURATION WARNING SYSTEM OPERATED NORMALLY. AIRCRAFT RETURNED TO SERVICE.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Flight Crew: Yes

When Event Detected:

Taxi: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Contacted Maintenance: Yes

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Narrative:

N/A.

Deidentified Crewmembers Analyst SSE Report 508

Overview:

Processing:

Status: Closed

ID: 508

Date/Time When Event Occurred: Tue, 24 Jan 2012 21:45 Z

Local Time When Event Occurred: 15:45

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 27 Jan 2012 21:12 Z

Submission Date/Time: Fri, 27 Jan 2012 21:12 Z

Source: Web Submission

Debrief Narrative: In hangar on GPU power. Operated all electrical systems. Verified operation of all cooling fans in the AFIS rack, IRU blower, and EFIS blower. Found weak air flow to the AFIS CDU. Repaired restricted hose. Checked all components for evidence of overheating. Found no further problems. Returned aircraft to service.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: Memphis Center

Aircraft Configuration:

Nickname: N74

Tail Number: N74

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Airport: UOX/KUOX

Narrative:

On January 24, 2012, I was the PIC on a flight inspection mission, in N74, tasked to accomplish a periodic with monitors on UVD localizer, in Oxford, MS. During the inspection, we lost GPS updating (Honeywell), and shortly thereafter noticed a "burning electrical" smell. All three crew noticed the smell. We started to land, quickly at Oxford, but then noticed the smell to have dissipated. We discussed our situation, and elected to proceed to Memphis, TN, approximately 47 nm away. We pulled the GPS breaker on the aft breaker panel and turned off the mission power. We landed uneventfully at Memphis. We wrote up the discrepancy, and notified FICO maintenance. After a period of time, it was determined that the best course of action would be to MEL the discrepancy and proceed to a maintenance base the next morning.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Unknown.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Flight Status after Event:

Diversion: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 506

Overview:

Processing:

Status: Closed

ID: 506

Date/Time When Event Occurred: Sun, 15 Jan 2012 16:20 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 17 Jan 2012 14:21 Z

Submission Date/Time: Tue, 17 Jan 2012 14:25 Z

Source: Paper Submission

Debrief Narrative: Although a small dent was discovered during a Walk Around Inspection, no logbook or ILM entry was made for corrective action. Dent is deemed to be minor and will not adversely affect on aircraft operation.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N76

Tail Number: N76

Aircraft Type: BE-300

Narrative:

Final (4 NM's) 27R KDTW (Detroit, MI) for KDTW 27R ROC check; came close to a seagull (we assumed); after landing a post flight (all three of us) revealed nothing. Damage (dent) LH wing (under boot) found 01/17/12.

Cause

Narrative:

-

Detection

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 503

Overview:

Processing:

Status: Closed

ID: 503

Date/Time When Event Occurred: Fri, 06 Jan 2012 19:00 Z

Local Time When Event Occurred: 13:00

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 06 Jan 2012 21:02 Z

Submission Date/Time: Fri, 06 Jan 2012 21:02 Z

Source: Web Submission

Debrief Narrative: REMOVED AND REPLACED BLEED AIR FAIL SENCE LINE INR/H WHEEL WELL IAW TI 4128.2 CH. 26-11-00.OPS CHECKED GOOD.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: Kansas City Center

Aircraft Configuration:

Nickname: N84

Tail Number: N84

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

While at FL 190 enroute between KGCK and KOKC, PIC (PF) noticed the R BLD AIR FAIL Master Warning Light had illuminated. PF initiated immediate action items while PNF (SIC) consulted the PCL for additional items. SIC requested a descent from FL190 to 11,000' MSL due to loss of Rudder Boost IAW PCL.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

R BLD AIR FAIL Warning light illuminated.

Possible 'Melted or failed plastic bleed air failure warning line' (Pg E-19)

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Operated in Degraded Conditions: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Narrative:

Question concerning Volume II procedures:

Ref. pg E-13. The second note under the BLEED AIR FAIL procedures states that "The BLEED FAIL annunciator will not extinguish after closing the bleed-air valve." Moving the Right Bleed Air Switch to PNEU & ENVIR OFF did result in the extinguishing of the master warning annunciator.

Deidentified Crewmembers Analyst SSE Report 502

Overview:

Processing:

Status: Closed

ID: 502

Date/Time When Event Occurred: Thu, 05 Jan 2012 22:30 Z

Local Time When Event Occurred: 16:30

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 06 Jan 2012 01:26 Z

Submission Date/Time: Fri, 06 Jan 2012 01:26 Z

Source: Web Submission

Debrief Narrative: REPLACED DEFECTIVE #1 INVERTER & OPS CHKD GOOD IAW T.I.4128.2,CHAP 24-22-00

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: FTW ARTCC

Aircraft Configuration:

Nickname: N79

Tail Number: N79

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Geographic Location:

Navigational Aid/VORTAC: CHILDRESS (CDS)

Narrative:

This was the second flight on N79 after installation of ProLine 21 avionics. Aircraft entered holding at CDS VORTAC at FL280 to check VOR and DME receiver reception range. With Inverter #1 in use, red INVERTER warning annunciator illuminated. Per the emergency checklist, Inverter #2 was selected. The remainder of the flight was uneventful. On ProLine 21 aircraft, the only cockpit equipment lost when an inverter fails is the transponder, TCAS, and EGPWS.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Maintenance is investigating.

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Status after Event:

No Disruption: Yes

Suggestions

Narrative:

NA

Deidentified Crewmembers Analyst SSE Report 501

Overview:

Processing:

Status: Closed

ID: 501

Date/Time When Event Occurred: Fri, 09 Dec 2011 17:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 12 Dec 2011 17:35 Z

Submission Date/Time: Mon, 12 Dec 2011 17:35 Z

Source: Web Submission

Debrief Narrative: Replaced flex slide joint P/N 42272-200, replaced gaskets to APU LCV IAW 4107.2 chapter 36-10-07. No further bleed air leaks found. Ops check good.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N58

Tail Number: N58

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

During pre-flight checks at KBZN (Bozeman, MT) with APU/engines running (OAT -5C), DUCT OHEAT annunciator illuminated, which is not unusual when trying to warm cabin with temp controls at high heat. Abnormal checklist completed but annunciator did not extinguish after ten minutes. After discussions with SAC maintenance, the aircraft was shut down and allowed to cool. After ten minutes, the light had extinguished. Aircraft restarted normally and departed KBZN. Completed an hour of flight check work at KBIL at low altitude, then departed enroute for KSMF. Fifteen minutes after leveling at cruising altitude of FL380, the DUCT OHEAT annunciator again illuminated. The abnormal checklist was again completed. After evaluation, it was determined that it was the cockpit temperature controller that had been closed by the DUCT OHEAT sensor (cabin temperature controller worked normally). The light remained illuminated for the balance of the flight. Cockpit heating was not available; it was cold.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Upon investigation by SAC maintenance, it was determined that a bleed air leak in the tailcone was directing hot bleed air in the vicinity of the cockpit DUCT OHEAT sensor.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 499

Overview:

Processing:

Status: Closed

ID: 499

Date/Time When Event Occurred: Tue, 29 Nov 2011 21:20 Z

Local Time When Event Occurred: 13:20

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 30 Nov 2011 01:23 Z

Submission Date/Time: Wed, 30 Nov 2011 01:23 Z

Source: Web Submission

Debrief Narrative: Inspected tailcone bleed overheat detection IAW TI 4107.2 chap FIA 26-13-00 & checked for bleed air leak IAW TI 4107.2 chap 36. Ran engine & APU at MCR, all systems checked good. 11/30/11. Smoke & Fume Report and Service Difficulty Report submitted.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: Oakland Center

Aircraft Configuration:

Nickname: N58

Tail Number: N58

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

Both L & R Bleed Air lights illuminated followed by smoke and fumes in the cockpit/cabin.

Approximately 15 minutes after initial T.O. from KSMF during final level off at FL280, both L & R Bleed air lights illuminated simultaneously indicating a tailcone overheat condition. A normal descent was requested from ATC as the Bleed Air Failure checklist was referred to and accomplished. The crew elected to divert towards KRDD which was VFR and only 25 miles away while KSMF was calling 1/4sm in fog and was 95 miles away. Bleed air annunciators did not extinguish throughout checklist compliance until 5 minutes after accomplishing steps 3.c,d, and e (left bleed air switch was set to emergency and right bleed air switch was turned off). Power was kept at idle throughout the descent and upon leveling off at 10,500 while enroute to KRDD, the PF initiated an increase in power at which point the lights illuminated once again. Power was reduced again and while SIC was verifying landing performance numbers both PF and PNF noticed smoke and fumes in the cockpit in the form of a thin gray haze and acrid odor. Oxygen masks and smoke goggles were donned by all three crew members and an emergency was declared with ATC and an uneventful overweight landing (21,800lbs) was made at KRDD. The crew cleared the runway, shut down, and egressed normally in the hammerhead. Crash & Rescue responded and deemed aircraft safe for towing to the FBO. Aircraft is awaiting mx.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Cause TBD. PF suspecting that smoke and fumes may have possibly been the result of contaminants in, on, or around the bleed air ducting exposed to the unconditioned emergency bleed air. (Speculation only).

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Exercised Captain Emergency Authority: Yes

Declared Emergency with ATC: Yes

Landed in Emergency Condition: Yes

Contacted ATC: Yes

Operated in Degraded Conditions: Yes

Flight Status after Event:

Unplanned Emergency Landing: Yes

Diversion: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 498

Overview:

Processing:

Status: Closed

ID: 498

Date/Time When Event Occurred: Fri, 18 Nov 2011 19:45 Z

Local Time When Event Occurred: 13:45

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 18 Nov 2011 22:18 Z

Submission Date/Time: Fri, 18 Nov 2011 22:18 Z

Source: Web Submission

Debrief Narrative: FOUND LH COCKPIT AIR DUCT DISCONNECTED AT IB COUPLING, RECONNECTED AIR DUCT & RECLAMPED COUPLING, LEAK CK & OPERATIONAL CK OF PRESS SYS GOOD IAW TI 4107.2-1 CHAP 21-30-00 PG 210-211.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N56

Tail Number: N56

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

During the last portion of climb to FL340 the cabin altitude climbed at 1000 FPM. Level at FL340 the cabin altitude was 8500 and the pressure differential was 7.7. A normal descent was initiated. When the thrust levers were retarded the cabin altitude slowly climbed to approximately 9800, the PRESS SYS and EMER PRESS annunciators illuminated, and the emergency pressurization system engaged. The emergency/manual pressurization system reduced the cabin altitude to 8500 and held it to 14000 MSL at 10000 MSL the cabin altitude was 4000. ATC was advised that we had a pressurization problem and needed to descend but an emergency was not declared as the cabin altitude was held to 8500 or below. The abnormal PRESS SYS and EMER PRESS checklists were completed and a normal landing was made at KOKC.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Pressurization

Detection

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 497

Overview:

Processing:

Status: Closed

ID: 497

Date/Time When Event Occurred: Wed, 09 Nov 2011 23:15 Z

Local Time When Event Occurred: 17:15

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 10 Nov 2011 03:14 Z

Submission Date/Time: Thu, 10 Nov 2011 03:14 Z

Source: Web Submission

Debrief Narrative: REPLACED SHORTED UP PRESS. SW. & DEFECTIVE GEAR MOTOR IAW T.I. 4128.2, CHAP. 32-30-00, OPS CHKD GOOD ON RETRACTIONS. No other events of shorted switches have been reported.

Event: 1

Baseline Risk Assessment

Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: OKC Tower
Aircraft Configuration:
Nickname: N68
Tail Number: N68
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Geographic Location:
Airport: OKC/KOKC - 17R/35L

Narrative:
After placing handle down, landing gear failed to extend normally. The landing gear relay circuit breaker was tripped. Referred to POH and completed alternate gear extension procedure (manually pumped gear down). An emergency was declared as a precaution for landing. This was on a planned full-stop landing at OKC following 2.5 hour sortie; gear was cycled normally one other time at beginning of sortie.

Phase of Flight:
Flight Phase at Start of Event: Approach
Cause

Narrative:
Unknown.
Detection
How Event Detected:
Flight Crew: Yes
Other Aircraft/Pilot: Yes
Self Awareness/Scan: Yes
When Event Detected:
In-Flight: Yes

Reaction
Flight Crew:
Declared Emergency with ATC: Yes
Executed Go Around: Yes
Flight Status after Event:
Planned Emergency Landing: Yes
Suggestions
Narrative:
Unknown

Deidentified Crewmembers Analyst SSE Report 495

Overview:
Processing:
Status: Closed
ID: 495
Date/Time When Event Occurred: Sun, 06 Nov 2011 14:12 Z
Local Time When Event Occurred: 09:12
Viewer Accessible: Yes
Initial Notification Date/Time: Sun, 06 Nov 2011 15:31 Z
Submission Date/Time: Sun, 06 Nov 2011 15:31 Z
Source: Web Submission
Debrief Narrative: Replaced Graphics Processor and reseated TCAS Processor and OP system IAW T.I. 4128.2, Chapter 34. Part number off and on 071-01505-0101 SN off P1095 on P1082
Event: 1
Baseline Risk Assessment
Likelihood:

Severity:
Risk Factor:
Description
ATC Information:
ATC Radio Frequency (MHz): 120.3
Name of ATC Facility: ACY Tower
Aircraft Configuration:
Nickname: N73
Tail Number: N73
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Geographic Location:
Airport: ACY/KACY - 13/31
Narrative:
Prior to V1 the RADAR/TCAS MFD went blank and then alerted with "TCAS Processor failure". This occurred twice on the takeoff roll.
An Abort was announced by PNF (VN231) to the crew and ACY Tower.
Phase of Flight:
Flight Phase at Start of Event: Rejected Takeoff
Cause
Narrative:
Unknown reason why the event occurred.
Detection
How Event Detected:
Self Awareness/Scan: Yes
Reaction
Flight Crew:
Took Evasive Action: Yes
Flight Status after Event:
Rejected Takeoff: Yes
Suggestions
Narrative:
No suggestions offered.

Deidentified Crewmembers Analyst SSE Report 496

Overview:
Processing:
Status: Closed
ID: 496
Date/Time When Event Occurred: Thu, 03 Nov 2011 16:45 Z
Local Time When Event Occurred: 11:45
Viewer Accessible: Yes
Initial Notification Date/Time: Mon, 07 Nov 2011 15:59 Z
Submission Date/Time: Mon, 07 Nov 2011 16:00 Z
Source: Web Submission
Debrief Narrative: As of 11/09/2011, there has been no record of a pilot report or a maintenance sign-off to accompany this SSE.

Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N76
Tail Number: N76
Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Geographic Location:

Airport: CMH/KCMH - 10R/28L

Narrative:

During Post flight inspection crewmember noticed bird remains on Left wing leading edge, near fuel cap. No apparent damage to wing. Assumed bird was struck on final although no one noticed when the bird strike happened. Snarge sent.

Phase of Flight:

Flight Phase at Start of Event: Landing

Cause

Narrative:

.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

PostFlight: Yes

Reaction

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 494

Overview:

Processing:

Status: Closed

ID: 494

Date/Time When Event Occurred: Tue, 01 Nov 2011 12:30 Z

Local Time When Event Occurred: 08:30

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 01 Nov 2011 13:28 Z

Submission Date/Time: Tue, 01 Nov 2011 13:28 Z

Source: Web Submission

Debrief Narrative: Removed and replaced Copilot's Airspeed Indicator. Pitot/Static Test Set removed from aircraft after system ground tested and leak checked okay in ref to TI 4128.2-1 (31) & 4128.2

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N66

Tail Number: N66

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

During take-off roll, pilot not flying (PNF) noted rise in pilot flying's (PF) airspeed, cross checked right airspeed indicator and noted no airspeed indication. At 60kts IAS, there was still no indication on right side. PNF called "ABORT, ABORT, ABORT", PF immediately initiated the abort procedures without incident. Abort was initiated before 80kts. Aircraft was slowed and vacated runway with more than 1000' of runway remaining. PNF notified ATC of the aborted take-off. Aircraft taxied to parking without incident.

Phase of Flight:

Flight Phase at Start of Event: Takeoff

Cause

Narrative:

Maintenance still investigating cause.

Detection

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Took Evasive Action: Yes

Flight Status after Event:

Rejected Takeoff: Yes

Suggestions

Narrative:

Insufficient maintenance training to recommend an avoidance procedure. From crews perspective, continue aborted takeoff training. What could have been a significant event was not due to continuous, effective training.

Deidentified Crewmembers Analyst SSE Report 493

Overview:

Processing:

Status: Closed

ID: 493

Date/Time When Event Occurred: Thu, 27 Oct 2011 07:20 Z

Local Time When Event Occurred: 03:20

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 27 Oct 2011 08:57 Z

Submission Date/Time: Thu, 27 Oct 2011 08:57 Z

Source: Web Submission

Debrief Narrative: RELAMPED CAPSULE FOR GEAR INDICATION WITH ALL NEW BULBS. OPS CHECK GOOD. (VERIFIED THE BULB WAS BAD FOR THE LEFT GEAR LITE).

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N73

Tail Number: N73

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

Upon lowering the gear handle, the left main landing gear position indicator did not illuminate. The gear handle was left in the down position and the abnormal checklist for "Landing Gear Unsafe Indication" was accomplished in addition to the "Landing Gear Manual Extension" checklist. Ground Emergency equipment was in an alert 2 condition (positioned on the taxiways). Subsequent to landing, the aircraft was towed to parking by Midlantic Aviation. The event occurred prior to landing at ACY International. The event occurred at 0720Z. The crew was: PIC VN231 PNF, SIC VN324 PF, MS VN106.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Unknown reason why the landing gear position indicator did not illuminate.

Detection

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes
Reaction
Flight Crew:
Contacted ATC: Yes
Operated in Degraded Conditions: Yes
Flight Status after Event:
Precautionary Landing: Yes
Suggestions
Narrative:
No suggestions offered.

Deidentified Crewmembers Analyst SSE Report 492

Overview:
Processing:
Status: Closed
ID: 492
Date/Time When Event Occurred: Wed, 05 Oct 2011 13:00 Z
Local Time When Event Occurred: 09:00
Viewer Accessible: Yes
Initial Notification Date/Time: Wed, 05 Oct 2011 18:40 Z
Submission Date/Time: Wed, 05 Oct 2011 18:40 Z
Source: Web Submission
Debrief Narrative: Deferred with MEL Number: 215; Removed and replaced AC power monitor box, same as #1 disc on LP 132496, #2 inverter operation found good, Placcard removed. Ref TI 4128.2
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N83
Tail Number: N83
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Narrative:
Prior to crossing the Hold Short the Inverter annunciator and Master Warning light illuminated steady state (#1 inverter selected as #2 was MEL) no secondary indications displayed.
Phase of Flight:
Flight Phase at Start of Event: Taxi-Out
Cause
Narrative:
Unresolved maintenance issues associated with similar SSE on 9/30/11 and 10/4/11.
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
How Event Detected:
Flight Crew: Yes
When Event Detected:
Taxi: Yes
Reaction
Flight Crew:
Exercised Captain Emergency Authority: Yes
Contacted Maintenance: Yes
Contacted Operations: Yes
Flight Status after Event:

Flight Cancellation: Yes
Suggestions
Narrative:
No suggestions offered.

Deidentified Crewmembers Analyst SSE Report 491

Overview:
Processing:
Status: Closed
ID: 491
Date/Time When Event Occurred: Wed, 05 Oct 2011 07:00 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Wed, 05 Oct 2011 13:12 Z
Submission Date/Time: Wed, 05 Oct 2011 13:15 Z
Source: Paper Submission
Debrief Narrative: CLEANED AND INSPECTED PILOTS WINDSHIELD, NO DAMAGE FOUND.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N67
Tail Number: N67
Aircraft Type: BE-300
Narrative:
Over KATL at 2,000 AGL; bird impacted pilot's lower windshield.
160 KIAS, clear sky, night, small bird, snarge mailed to Smithsonian
Cause
Narrative:
-
Detection
Reaction
Suggestions

Deidentified Crewmembers Analyst SSE Report 490

Overview:
Processing:
Status: Closed
ID: 490
Date/Time When Event Occurred: Tue, 04 Oct 2011 18:15 Z
Local Time When Event Occurred: 14:15
Viewer Accessible: Yes
Initial Notification Date/Time: Wed, 05 Oct 2011 01:55 Z
Submission Date/Time: Wed, 05 Oct 2011 01:55 Z
Source: Web Submission
Debrief Narrative: Removed and replaced AC power monitor box, operation found good, Ref TI 4128.2
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N83

Tail Number: N83
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Narrative:
Aborted Takeoff prior to V1 due to illuminated Inverter light (inverter #2 selected) and Master Warning light.
Phase of Flight:
Flight Phase at Start of Event: Takeoff
Cause
Narrative:
Similar SSE on this same airframe was experienced 9/30/11. Unknown reason why the event occurred.
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
How Event Detected:
Flight Crew: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Exercised Captain Emergency Authority: Yes
Flight Status after Event:
Flight Cancellation: Yes
Rejected Takeoff: Yes
Suggestions
Narrative:
Review maintenance actions subsequent to 9/30/11 (inverter #1 selected) and refine troubleshooting.

Deidentified Crewmembers Analyst SSE Report 488

Overview:
Processing:
Status: Closed
ID: 488
Aware Date/Time: Fri, 30 Sep 2011 13:30 Z
Date/Time When Event Occurred: Thu, 29 Sep 2011 13:30 Z
Local Time When Event Occurred: 09:30
Viewer Accessible: Yes
Initial Notification Date/Time: Mon, 03 Oct 2011 13:53 Z
Submission Date/Time: Mon, 03 Oct 2011 13:54 Z
End of Trip Date/Time: Fri, 30 Sep 2011 16:30 Z
Source: Web Submission
Debrief Narrative: Inspected #1 inverter for security of installation, performed OPS check, no defects were noted. Ref 300 MM 24-00-00 + TI 4128.2 chg 166. Work performed by Landmark Aviation,
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N83
Tail Number: N83
Aircraft Type: BE-300
Flight Crew Employee Information:
Duty Off Time: Fri, 30 Sep 2011 20:00 Z
Duty On Time: Fri, 30 Sep 2011 11:30 Z
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Flight Information:

Flight Number: FLC83

Narrative:

During take-off roll after 80kts prior to V1, PNF (VN137) observed illumination of RED INVERTER light.

ABORT called out and identified INVERTER annunciator illuminated, and PF (VN324) brought A/C to safe stop and cleared runway.

Memory item for failure completed, Emer Chk List verified. (switch to other inverter).

Red light cleared. Re-test INVERTER system Pre-Flight Check, checked satisfactory.

No indication of AC power loss during RED INVERTER light illumination.

Phase of Flight:

Flight Phase at Start of Event: Rejected Takeoff

Weather:

Meteorological Conditions: VMC

Weather Description: Clear

Cause

Narrative:

Illumination of RED INVERTER light during take-off roll initiated the aborted take-off.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Flight Crew: Yes

Reaction

Flight Status after Event:

Rejected Takeoff: Yes

Narrative:

This was the start of the third flight since major service performed. Since this A/C was recently returned to service after a major inspection it was decided to have a mechanic verify system operation and integrity.

Suggestions

Deidentified Crewmembers Analyst SSE Report 487

Overview:

Processing:

Status: Closed

ID: 487

Date/Time When Event Occurred: Wed, 21 Sep 2011 22:00 Z

Local Time When Event Occurred: 17:00

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 22 Sep 2011 14:12 Z

Submission Date/Time: Thu, 22 Sep 2011 14:12 Z

Source: Web Submission

Debrief Narrative: Found lft M/G ind. light bulb open- R/R all ind light bulbs with new / jacked A/C, cycled gear, checked res fluid & accum pressure - ops check sat. 3 green on ind, all work done IAW TI 4128.2 ch 7, 33, & 32-end- Work performed by Stevens Aviation Inc

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N77

Tail Number: N77

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

On visual approach to runway 2C at KBNA. During Before Landing Checklist, Pilot Flying noted left main gear indicator failed to illuminate, red light in handle was extinguished. We consulted and executed Landing Gear Manual Extension checklist, landed normally, cleared runway, shutdown aircraft and had it towed to a maintenance location.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Light bulb burned out

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Declared Emergency with ATC: Yes

Landed in Emergency Condition: Yes

Contacted ATC: Yes

Executed Go Around: Yes

Flight Status after Event:

Planned Emergency Landing: Yes

Suggestions

Narrative:

Replace landing gear indicators with a module that has multiple bulbs or that has LED for illumination.

Deidentified Crewmembers Analyst SSE Report 489

Overview:

Processing:

Status: Closed

ID: 489

Date/Time When Event Occurred: Wed, 21 Sep 2011 14:00 Z

Local Time When Event Occurred: 10:00

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 03 Oct 2011 14:59 Z

Submission Date/Time: Mon, 03 Oct 2011 14:59 Z

Source: Web Submission

Debrief Narrative: Cleaned and inspected area of birdstrikeabove copilots window. No Damage was noted. Work performed , 9-22-11,

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N81

Tail Number: N81

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

During Flight Inspection manuevers, 1500 feet AGL, 180 KIAS, in the KLUK area, crew heard a mild splat and noticed yellow and white splatter remains on the copilot's windscrene, believed to be a large insect. After landing we asked ground personel to clean the windscrene. The ground person informed us that there were remains, feathers and blood of a small bird above the windscrene. FICO maintenance notified. Aircraft inspected and returned to service. No snarge collected.

Phase of Flight:

Flight Phase at Start of Event: Holding

Cause
Narrative:
Bird and aircraft occupying the same space.
Detection
How Event Detected:
Maintenance Personnel: Yes
When Event Detected:
PostFlight: Yes
Reaction
Flight Crew:
Contacted Company: Yes
Contacted Maintenance: Yes
Contacted Operations: Yes
Flight Status after Event:
Flight Delay: Yes
Suggestions
Narrative:
None.

Deidentified Crewmembers Analyst SSE Report 486

Overview:
Processing:
Status: Closed
ID: 486
Date/Time When Event Occurred: Tue, 13 Sep 2011 14:50 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Tue, 13 Sep 2011 19:16 Z
Submission Date/Time: Tue, 13 Sep 2011 19:19 Z
Source: Paper Submission
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N81
Tail Number: N81
Aircraft Type: BE-300
Narrative:
Flying flight inspection holding patterns at KMKE. Had a bird strike. No damage.
KMKE, 07R, 1500 AGL, 160 KIAS, Sky Clear, Wing struck by 1 small bird, Snarge mailed to Smithsonian.
Cause
Narrative:
-
Detection
Reaction
Suggestions

Deidentified Crewmembers Analyst SSE Report 483

Overview:
Processing:
Status: Closed
ID: 483
Date/Time When Event Occurred: Fri, 02 Sep 2011 12:20 Z
Local Time When Event Occurred: 08:20

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 02 Sep 2011 13:24 Z

Submission Date/Time: Fri, 02 Sep 2011 13:26 Z

Source: Web Submission

Debrief Narrative: OPS CHECKED RIGHT AND LEFT FLO PACKS NOTED ACRID SMELL FROM RIGHT PACK WHEN LEFT PACK IS TURNED OFF ALSO NOTICED RIGHT BLEED AIR OFF LIGHT WAS INTERMITTENT AND THEN SOLID FAIL.REMOVED AND REPLACED RIGHT FLOW PACK AND ELECTRONIC CONTROLLER OPS CHECK TI4128.2 CH 36

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N73

Tail Number: N73

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

Upon takeoff and initial climb out all crewmembers noticed abnormal smell; Mission Specialists (2) noted haze throughout cabin which reduced visibilty, non-flying pilot confirmed; IFR cancelled, flying pilot executed reversal and precautionary landing back at departure point.

Phase of Flight:

Flight Phase at Start of Event: Takeoff

Cause

Narrative:

Maintenance is investigating at this time

Detection

How Event Detected:

Cabin Crew: Yes

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Status after Event:

Precautionary Landing: Yes

Air Turnback: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 484

Overview:

Processing:

Status: Closed

ID: 484

Date/Time When Event Occurred: Thu, 01 Sep 2011 18:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 02 Sep 2011 14:01 Z

Submission Date/Time: Fri, 02 Sep 2011 14:08 Z

Source: Paper Submission

Debrief Narrative: INSPECTED LT AND RT AILERON DRIVE MECHANISM AND LUBED BRUSH SEALS IAW TI4128.2 CH 27-21-02.REMOVED LEFT AILERON AND REPLACED BEARING SUPPORT ASSY BEARINGS, AILERON HINGE BEARINGS AND YOKE BEARINGS. REINSTALLED LEFT AILERON AND RESET AND RIGGED CABLES AND CHECKED AILERON TRAVEL. SYSTEM OPS CHECKED GOOD. ALL WORK DONE IAW 4107.2 CHAP 27-10-02 AND 27-10-00 AND 27-10-10.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N56

Tail Number: N56

Aircraft Type: LR-60

Narrative:

During the spoileron check the aircraft ailerons had a pronounced "detent" at the neutral position. Aileron control movement was not smooth when moving yoke left to right or right to left. The detent remained regardless of aircraft configuration. Controls should be smooth, free, and correct prior to flight. They were not so we did not fly the aircraft. The SIC, Mr. Burdette, confirmed that in his experience this is not a normal condition on the LR60.

We physically moved the ailerons and noticed the same detent at the neutral position and could feel additional smaller detents/roughness during aileron travel.

N54 was also on the ramp so we compared aileron feel and smoothness. We did not detect any detents or roughness in the ailerons of N54 either by physical movement of the ailerons or input with the yoke.

This is a repeat discrepancy. It was written up on 8/31/11 .

Cause

Narrative:

-

Detection

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 485

Overview:

Processing:

Status: Closed

ID: 485

Date/Time When Event Occurred: Thu, 01 Sep 2011 14:00 Z

Local Time When Event Occurred: 09:00

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 02 Sep 2011 15:19 Z

Submission Date/Time: Fri, 02 Sep 2011 15:19 Z

Source: Web Submission

Debrief Narrative: ILM entry/Non-Routine not initiated. Corrective Action not required due to no aircraft damage being noted.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N66

Tail Number: N66

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

FLIGHT INSPECTION LOW APPROACH AT 50' AGL BIRD STRIKE BELOW CP WINDOW. FLEW CLOSED TRAFFIC AND LANDED. NO DAMAGE TO AIRCRAFT, SMALL STREAK OF BLOOD BELOW COPILOT SIDE WINDOW. NOTHING TO COLLECT FOR KIT. LOCATION KUCY, TN.

Phase of Flight:
Flight Phase at Start of Event: Go Around
Cause
Narrative:
BIRDS
Detection
How Event Detected:
Flight Crew: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Contacted Operations: Yes
Executed Go Around: Yes
Flight Status after Event:
Precautionary Landing: Yes
Suggestions
Narrative:
NONE

Deidentified Crewmembers Analyst SSE Report 482

Overview:
Processing:
Status: Closed
ID: 482
Date/Time When Event Occurred: Wed, 31 Aug 2011 17:00 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Thu, 01 Sep 2011 20:16 Z
Submission Date/Time: Thu, 01 Sep 2011 20:52 Z
Source: Paper Submission
Debrief Narrative: INSPECTED LT AND RT AILERON DRIVE MECHANISM AND LUBED BRUSH SEALS IAW T14128.2 CH 27-21-02.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N56
Tail Number: N56
Aircraft Type: LR-60
Narrative:
FL 330 between KDRT and KOKC; ailerons binding on both sides, near where the spoileron test limits are associated.
Cause
Narrative:
-
Detection
Reaction
Suggestions

Deidentified Crewmembers Analyst SSE Report 480

Overview:
Processing:
Status: Closed
ID: 480
Date/Time When Event Occurred: Tue, 30 Aug 2011 19:30 Z

Viewer Accessible: Yes
Initial Notification Date/Time: Wed, 31 Aug 2011 15:52 Z
Submission Date/Time: Thu, 01 Sep 2011 14:34 Z
Source: Paper Submission
Debrief Narrative: Removed + replaced bleed air sense line in right wheel well, IAW TI 4128.2 ch 26-00-00. OPS & leak check good.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N70
Tail Number: N70
Aircraft Type: BE-300
Narrative:
Departed KAEX for KMSY.
Right bleed air light illuminated. Memory items accomplished -- right environmental / pneumatic switch placed to off position.
Referenced checklist -- no other action required. Aircraft recovered to KMSY with no incident.
Cause
Narrative:
-
Detection
Reaction
Suggestions

Deidentified Crewmembers Analyst SSE Report 481

Overview:
Processing:
Status: Closed
ID: 481
Date/Time When Event Occurred: Tue, 30 Aug 2011 18:06 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Tue, 30 Aug 2011 17:48 Z
Submission Date/Time: Thu, 01 Sep 2011 14:44 Z
Source: Paper Submission
Debrief Narrative: Cleaned area of birdstrike, Inspected area of birdstrike and found no damage to structure, paint or area, IAW standard MX practices.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N85
Tail Number: N85
Aircraft Type: CL-601
Narrative:
Bird strike on lower center forward of nose gear door; approximately 100 ft AGL on approach to KGRI.
Phase of Flight:
Flight Phase at Start of Event: Approach
Cause
Narrative:
-
Detection
Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 479

Overview:

Processing:

Status: Closed

ID: 479

Date/Time When Event Occurred: Wed, 10 Aug 2011 18:15 Z

Local Time When Event Occurred: 13:15

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 11 Aug 2011 22:39 Z

Submission Date/Time: Thu, 11 Aug 2011 22:39 Z

Source: Web Submission

Debrief Narrative: Removed and Replaced the R/H engine bleed valve. Lk & Op ck good IAW TI 4107.2

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N54

Tail Number: N54

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

After gear retraction pack overheat illuminated combined with right bleed fail annunciator and master warning annunciator. Selected pack bypass and left bleed air fail annunciator illuminated. Commenced shut down of both bleed valves and both bleed air fail annunciators extinguished. ATC notified, established in holding on the final for runway 21 to burn down to landing weight. Accomplished pack overheat and bleed fail checklists. Normal landing was accomplished without incident. An emergency was not declared.

Phase of Flight:

Flight Phase at Start of Event: Initial Climb

Cause

Narrative:

Maintenance is investigating.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Operated in Degraded Conditions: Yes

Flight Status after Event:

Air Turnback: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 478

Overview:

Processing:

Status: Closed

ID: 478

Date/Time When Event Occurred: Tue, 02 Aug 2011 20:30 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 02 Aug 2011 21:47 Z

Submission Date/Time: Wed, 03 Aug 2011 13:33 Z

Source: Paper Submission

Debrief Narrative: FAA Maintenance performed engine download sent to PWC Engineering.

PWC Engineering requests PWC MRT to remove and replace DOV

solenoid. PWC MRT removed and replaced BOV solenoid IAW PWC 305A

MM P/N 3031402 rev 58 dated 10/10/10 ch 75-30-02. Engine performed

satisfactory. Maintenance/Performance check IAW PWC 305A MM P/N

3031402 rev 58. Work performed by P&W CRS RT5R183R2, 08/05/2011 KEUG Part number off 31B4197-04 SN 053 PN

on 31B4197-05 SN ARK0668T

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N58

Tail Number: N58

Aircraft Type: LR-60

Narrative:

Descending to 1,000 MSL for KOTH Rwy 31 (North Bend, OR) PAPI check; VN096 (SIC) in right seat noted oil pressure light. Go-around initiated. Right engine scan revealed engine rollback with zero oil pressure. Climb to 7,500 with divert to KEUG initiated. Engine shutdown checklist completed. At cruise, air start attempted. With ITT climbing, oil pressure remained at zero. Start terminated. Single engine landing checklist completed. Overweight landing, 20,300, completed without incident. Smooth touchdown with minimum braking to end of runway accomplished. Emergency services requested but not required. VFR throughout.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

*

Detection

How Event Detected:

Flight Crew: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 476

Overview:

Processing:

Status: Closed

ID: 476

Date/Time When Event Occurred: Fri, 20 May 2011 17:30 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 20 May 2011 18:52 Z

Submission Date/Time: Fri, 20 May 2011 18:52 Z

Source: Web Submission

Debrief Narrative: Removed and replaced outboard MLG door attach fitting IAW Ti 4107.2 chapter 32. Ops check good. Installed P/N 5422153-1.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N55

Tail Number: N55

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

During routine flight the MS reported hearing a subtle vibration noise that changed with aircraft speed. As speed increased, the frequency of the noise increased as well, and vice versa. The PIC and SIC could not hear the vibration, but noticed a minor whistle that sounded like someone blowing across an open glass bottle. No abnormal indications were present (i.e. annunciators, aircraft handling issues, or visible aircraft damage). The crew discussed possible causes to include environmental, flap, spoiler, gear, bird strike, antenna separation, etc... Investigation of each area revealed no conclusive evidence. When the crew landed at home base, aircraft mx personnel discovered that the left main landing gear, outboard gear door attachment point, was cracked and separated where the gear door mechanically connects to the landing gear itself. Note: There was no visible damage to the area where the gear door attaches to the wing.

Phase of Flight:

Flight Phase at Start of Event: Climb

Cause

Narrative:

The noise heard by the crew was most likely the result of the left main gear door partially or fully sagging into the slipstream.

Detection

How Event Detected:

Flight Crew: Yes

Maintenance Personnel: Yes

When Event Detected:

In-Flight: Yes

PostFlight: Yes

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 475

Overview:

Processing:

Status: Closed

ID: 475

Date/Time When Event Occurred: Thu, 12 May 2011 17:45 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 16 May 2011 18:47 Z

Submission Date/Time: Mon, 16 May 2011 18:47 Z

Source: Web Submission

Debrief Narrative: Removed L/H top aft eng cowling, removed cleaned and reinstalled generator ground clip, reinstalled cowling. Swapped GCUs for troubleshooting, left in position R/H S/N 1156, L/H S/N 1159. completed ground runup, charging system operation normal. Work performed by Executive Beechcraf DBA Signature Technic Air, CRS# AKGR142C

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N84

Tail Number: N84

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

While enroute to KOKC with the #1 inverter deferred (MEL), both load meters were varying between 31-40% load and the battery charge meter was also varying between 0-6 Amps of load (+). Verified that neither the aircraft strobes nor rotating beacon were causing the fluctuations. Immediately notified ATC and a precautionary landing was made at KMCI.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Upon landing, MX had found a corroded ground on an engine firewall. Also, Mx found inverter #1 now operating normally as well.

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Operations: Yes

Operated in Degraded Conditions: Yes

Flight Status after Event:

Precautionary Landing: Yes

Diversion-Other Alternate: Yes

Flight Cancellation: Yes

Flight Delay: Yes

Suggestions

Narrative:

None other than to consider aging aircraft fleet.

Deidentified Crewmembers Analyst SSE Report 474

Overview:

Processing:

Status: Closed

ID: 474

Date/Time When Event Occurred: Thu, 12 May 2011 02:30 Z

Local Time When Event Occurred: 22:30

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 12 May 2011 03:04 Z

Submission Date/Time: Thu, 12 May 2011 03:04 Z

Source: Web Submission

Debrief Narrative: REMOVED AND REPLACED R/H AILERON TIP CAP, IAW TI4128.2 CHAPTER 27. AILERON WAS BALANCED IAW TI4128.2 CHAPTER 57. REFERENCE MADE TO TI4128.3 CHAPTER 20 FOR SHEETMETAL. P/N ON AND OFF 101-130001-212U.; NSN ASSIGNED.RII ROBERT SCARLETT.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N76

Tail Number: N76

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Narrative:

On preflight SIC noticed a crack in the outermost portion of the right aileron. Upon completion of preflight SIC notified VN231 and requested he view the area in question. Subsequent to release and prior to boarding the aircraft, VN231 viewed the crack and

determined it unsafe for flight. VN231 wrote in discrepancy section of logbook page 115776 "Surface crack clean through plastic portion right aileron - outside edge to top of control surface". VN 231 contacted FICO Operations and Boston TraCon of cancellation of the evenings flight check.

Phase of Flight:

Flight Phase at Start of Event: Predeparture/Preflight

Cause

Narrative:

Not applicable. See above narrative.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

PreFlight: Yes

Reaction

Flight Crew:

Contacted Operations: Yes

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Narrative:

Not applicable. See above narrative.

Deidentified Crewmembers Analyst SSE Report 473

Overview:

Processing:

Status: Closed

ID: 473

Date/Time When Event Occurred: Sat, 30 Apr 2011 18:30 Z

Local Time When Event Occurred: 14:30

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 02 May 2011 12:43 Z

Submission Date/Time: Mon, 02 May 2011 12:43 Z

Source: Web Submission

Debrief Narrative: EVA TUBING REPOSITIONED,AND REPAIRED WITH P/N 101-970093 SPLICE,IN AREA OF RT CTR SECT TO NACELLE(FWD).OPERATIONAL CHECK GOOD,NO DISCREPANCIES NOTED,IAW TI 4128.2

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N70

Tail Number: N70

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

R BL AIR FAIL annunciator illuminated during climb passing approximately 13,000 feet after departure from KSDF. Executed boldface emergency procedures then consulted checklist. No further action required, flight continued to home base (destination.)

Phase of Flight:

Flight Phase at Start of Event: Climb

Cause

Narrative:

Failure in the bleed air system

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Operated in Degraded Conditions: Yes
Flight Status after Event:
No Disruption: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 471

Overview:
Processing:
Status: Closed
ID: 471
Date/Time When Event Occurred: Thu, 21 Apr 2011 19:11 Z
Local Time When Event Occurred: 16:11
Viewer Accessible: Yes
Initial Notification Date/Time: Fri, 22 Apr 2011 00:15 Z
Submission Date/Time: Fri, 22 Apr 2011 00:15 Z
Source: Web Submission
Notes: Bob Stuckert filed notification with NTSB on 04/22/11.

Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N66
Tail Number: N66
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:
FLC66 IFR IN IMC AT 5000 MSL IN CONTACT WITH(ILM) ATC, APPROCH CONTROL FOR LANDING AT KILM .ATC ADVISES TRAFFIC 11 OCLOCK /TCAS ALSO REPORTED TRAFFIC AS A (TA) ATC STATED TARGET UNKNOWN WAS AT 4700 MSL AN CLIMBING,/THEN GOT A (RA) TO CLIMB NOW, NOW/PILOT VN141 STARTED CLIMB TO 6000 MSL NOTIFIED ATC OF OUR REQUIRED ACTION,HELD 6000MSL UNTIL CLEAR OF TRAFFIC/NO TIME WAS TRAFFIC INSIGHT,ATC CLEARED FLC66 TO 3000 MSL THEN LANDING KILM. NO ADDITIONAL ACTION REQUIRED

Phase of Flight:
Flight Phase at Start of Event: Cruise
Cause

Narrative:
AT 5000 MSL HAD A TCAS TA GO TO A TCAS RA

Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
How Event Detected:
ATC: Yes
Flight Crew: Yes
Self Awareness/Scan: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Exercised Captain Emergency Authority: Yes

Took Evasive Action: Yes
Flight Status after Event:
No Disruption: Yes
Suggestions
Narrative:
NONE

Deidentified Crewmembers Analyst SSE Report 470

Overview:

Other Employees:

Employee Duty: Pilot Monitoring/Pilot Not Flying

First Name: Michael

Last Name: Bond

Other Employees:

Employee Duty: Mission Specialist

First Name: Ryan

Last Name: Hickey

Processing:

Status: Closed

ID: 470

Aware Date/Time: Tue, 05 Apr 2011 17:15 Z

Date/Time When Event Occurred: Tue, 05 Apr 2011 17:15 Z

Local Time When Event Occurred: 13:15

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 05 Apr 2011 18:32 Z

Submission Date/Time: Tue, 05 Apr 2011 18:37 Z

End of Trip Date/Time: Tue, 05 Apr 2011 17:30 Z

Source: Web Submission

Debrief Narrative: REMOVED AND REPLACED DEFECTIVE R/H PROP PROXIMITY SWITCH. OP CHECKS GOOD IAW TI4128.2 CHAPTER 76-00-00 AND 61-20-00. SAFETIED JAM NUTS AND REINSTALLED TOP COWLING.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

ATC Information:

Name of ATC Facility: Washington center

Aircraft Configuration:

Nickname: N76

Tail Number: N76

Aircraft Type: BE-300

Speed IAS (Knots): 250

Flight Crew Employee Information:

Duty Off Time: Tue, 05 Apr 2011 20:00 Z

Duty On Time: Tue, 05 Apr 2011 11:30 Z

Primary Duties During Time of Event: Pilot Flying

Flight Information:

Departure Airport, Runway and Gate: ACY/KACY

Time of Day: Daylight

Non-Revenue Flight: Normal Operations

Scheduled Arrival Airport, Runway and Gate: ACY/KACY

Landing Airport, Runway and Gate: ACY/KACY

Filed Altitude (MSL): 16000

Geographic Location:

Navigational Aid/VORTAC: MODENA (MXE)

Waypoint/Fix: MXE MODENA

Narrative:

In cruise flight 16000 msl, 30 NE of MXE VOR. R Prop Pitch annunciator illuminated. No other indications on instruments. No affects on aircraft handling were detected in flight. Elected to return to KACY. In anticipation of possible assymetric thrust on landing, declared emergency so that emergency equipment would be standing by.

A "flaps approach" landing was conducted and some yaw was felt just prior to touchdown. Landing was uneventful with the exception that left main landing gear outboard tire was found blown on shutdown. This was not detected on the landing.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Weather:

Meteorological Conditions: IMC

Cause

Narrative:

Apparent failure of the R ground idle low pitch stop.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

Narrative:

R Prop Pitch annunciator illuminated.

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Declared Emergency with ATC: Yes

Flight Status after Event:

Precautionary Landing: Yes

Narrative:

Declared emergency. Returned to KACY. Briefed possible affects and landing and plan to go around if loss of directional control was determined as power was rolled back on landing.

Suggestions

Narrative:

None.

Deidentified Crewmembers Analyst SSE Report 469

Overview:

Processing:

Status: Closed

ID: 469

Date/Time When Event Occurred: Mon, 28 Mar 2011 04:10 Z

Local Time When Event Occurred: 00:10

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 29 Mar 2011 00:23 Z

Submission Date/Time: Tue, 29 Mar 2011 00:23 Z

Source: Web Submission

Debrief Narrative: REMOVED LH ENGINE LOWER FORWARD COWLING & INSPECTED. FOUND AFT WELD ASSY. (VANE) DENTED AND LOOSE. REMOVED ENGINE INLET SCREEN & INSPECTED INLET, NO DAMAGE NOTED, REPLACED SCREEN. REPLACED LOWER COWLING WITH COWLING CANNIBALIZED FROM N81

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N80

Tail Number: N80

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

During night flight inspection of KDTW ILS Rwy 27L (ILS-2 maneuver), at 0410z/0010EDT, 10 NM east of KDTW (over the Detroit River), 2100' MSL, clean configuration, mission specialist heard a noise. PIC did not hear anything unusual. All engine and other aircraft indications normal, so mission was continued. On landing/shut-down, found bird remains stuck to inboard part of left engine intake "lip," with blood and other remains splattered onto wings and engine nacelle. Remains visible inside engine inlet, blood visible seeping out between panels on side of engine cowling. A few pin feathers were stuck to one prop de-ice boot. No damage noted. Notified FICO and collected remains for SNARGE kit (kit mailed).

Upon maintenance inspection, found engine ice vane bent but still operable. Turbine blades, screen, etc. all OK.

Engine ice vanes were in the "OFF" position at the time of the strike.

Phase of Flight:

Flight Phase at Start of Event: Holding

Cause

Narrative:

We hit a bird.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

PostFlight: Yes

Reaction

Flight Crew:

Contacted Operations: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Narrative:

N/A. NOTAM "02/031 DTW AD BIRDS AND COYOTES ON AIRFIELD" was in place at time of bird strike.

Deidentified Crewmembers Analyst SSE Report 468

Overview:

Processing:

Status: Closed

ID: 468

Date/Time When Event Occurred: Mon, 14 Mar 2011 21:10 Z

Local Time When Event Occurred: 15:10

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 15 Mar 2011 02:32 Z

Submission Date/Time: Tue, 15 Mar 2011 02:32 Z

Source: Web Submission

Debrief Narrative: Inspected visually RH engine area. Performed engine run-up at normal TO and MCT. Engine operational check good. BOV check also good IAW TI 4107.7.2. Work completed, RU3A796U, KBOI, 3/15/11

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N58

Tail Number: N58

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

The flight was the 2nd sortie of the day and departed from KBOI (Boise ID) for ROC checks at KMYL (McCall ID) enroute to KBFI (Boeing Field, WA). The event occurred approximately 20 minutes into the flight in VFR conditions. We had completed the 1st ROC check at KMYL on RWY 34 with a low approach and were in a slow climb to 8,900' to set up for the GPS to RWY 16. Just prior to the level-off at 8,900' the #2 engine (RT) began to produce a vibration and noise that was equivalent to that of a car riding on the rumble strips in the shoulder of a road. At that same time, the PNF noticed the #2 engine parameters had rolled back to idle indications on the engine instruments. There were no annunciators of any kind associated with the rollback and vibration. I (PF) reduced the #2 thrust lever to idle to minimize the vibration and called for the abnormal/emergency checklists to be run. The vibration subsided approximately 5 seconds after initial onset. We turned back towards KBOI, declared an emergency, and continued the climb to 13,000' MSL with the #1 engine operating at MCT and the #2 engine at idle. Note: KMYL did not have adequate runway length for an emergency landing making KBOI (70nm South) the closest suitable airport. All applicable checklists were run during the climb and the #2 engine had stabilized in the idle position. Upon reaching 13,000' MSL and in stable cruise at 250 KIAS, the crew cautiously brought up the #2 engine to approximately 70% to match #1 engine. All parameters on both engines remained in the normal range for the remainder of the flight back to KBOI. The crew elected to fly a two engine approach using the single engine landing procedure and configuration in the event that the #2 engine could possibly roll back again. The aircraft was landed uneventfully below landing weight and remains at KBOI pending MX. No immediate visible engine damage was noticed by the crew upon an initial cursory post flight inspection of the #2 engine.

Phase of Flight:

Flight Phase at Start of Event: Climb

Cause

Narrative:

N/A

Detection

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Declared Emergency with ATC: Yes

Corrected Pitch/Power: Yes

Flight Status after Event:

Unplanned Emergency Landing: Yes

Diversion-Filed Alternate: Yes

Diversion: Yes

Suggestions

Narrative:

N/A

Deidentified Crewmembers Analyst SSE Report 467

Overview:

Processing:

Status: Closed

ID: 467

Aware Date/Time: Thu, 03 Mar 2011 14:00 Z

Date/Time When Event Occurred: Thu, 03 Mar 2011 14:00 Z

Local Time When Event Occurred: 09:00

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 04 Mar 2011 19:54 Z

Submission Date/Time: Fri, 04 Mar 2011 19:55 Z

End of Trip Date/Time: Fri, 04 Mar 2011 21:00 Z

Source: Web Submission

Debrief Narrative: Inspected and found RH fuel cap lanyard broken and caught underneath fuel cap. Removed lanyard, re-installed fuel cap, and Ops checked good at this time. Corporate Air LLC, KAGC.

Event: 1

Baseline Risk Assessment

Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: PIT
Aircraft Configuration:
Nickname: N76
Tail Number: N76
Aircraft Type: BE-300
Seat Belt Sign: On
Speed IAS (Knots): 250
Aircraft System/Equipment Malfunction:
Equipment Malfunction: FUEL CAP SEAL
Flight Crew Employee Information:
Duty Off Time: Thu, 03 Mar 2011 23:30 Z
Duty On Time: Thu, 03 Mar 2011 12:30 Z
Primary Duties During Time of Event: Pilot Flying
Flight Information:
Departure Airport, Runway and Gate: AGC/KAGC - 10/28
Flight Number: FLC 76
Time of Day: Daylight
Scheduled Arrival Airport, Runway and Gate: CHO/KCHO - 03/21
Landing Airport, Runway and Gate: CHO/KCHO - 03/21
Filed Altitude (MSL): 13000
Geographic Location:
Airport: AGC/KAGC - 10/28
Narrative:
AFTER TAKEOFF FUEL WAS STREAMING FROM RIGHT MAIN FUEL CAP WITH THE FUEL CAP FLUSH WITH AIRCRAFT SURFACE.
Phase of Flight:
Flight Phase at Start of Event: Takeoff
Weather:
Meteorological Conditions: VMC
Cause
Narrative:
IT WAS DETERMINED AFTER THE EVENT THAT THE FUEL CAP LANYARD WAS BROKEN AND CAUGHT BETWEEN THE CAP AND IT'S SEAL.
Station Ops Complications-Operations:
Station Ops Complications-Operations: Yes
Detection
How Event Detected:
Flight Crew: Yes
Self Awareness/Scan: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Status after Event:
Precautionary Landing: Yes
Air Turnback: Yes
Flight Delay: Yes
Flight Delay Duration (Min): 210
Narrative:
N76 ENTERED DOWNWIND AND ASKED FOR PRIORITY HANDLING FROM TOWER. LANDING WAS UNEVENTFUL. HAZMAT TRUCK WAS REQUESTED DUE TO FUEL SPILL WHILE AT FBO AFTER THE AIRBORNE EVENT.
Suggestions

Deidentified Crewmembers Analyst SSE Report 465

Overview:

Processing:

Status: Closed

ID: 465

Date/Time When Event Occurred: Tue, 15 Feb 2011 20:10 Z

Local Time When Event Occurred: 14:10

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 17 Feb 2011 16:28 Z

Submission Date/Time: Thu, 17 Feb 2011 16:28 Z

Source: Web Submission

Debrief Narrative: T/S/SYSTEM AND FOUND LEFT NOSE GEAR DOOR PROX SWITCH INOP (CLOSED) ALSO FOUND NOSE GEAR UPLOCK PROX SWITCH INOP (CLOSED) REMOVED AND REPLACED BOTH PROX SWITCHES IAW 4109.2 CHAP 32. CYCLIED GEAR SEVERAL TIMES, OPS CHECKED GOOD.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N87

Tail Number: N87

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Check Airman

Narrative:

After takeoff the landing gear handle was moved to the up position. Both main gear retracted, but the nose gear did not retract. The only indication in the cockpit was one green nose gear down light.

Holding was coordinated with ATC and the FICO was notified. Emergency and normal checklists were accomplished. Normal gear down indications were observed in the cockpit.

A tower fly-by was accomplished to confirm that all landing gear appeared to be extended.

An emergency was not declared and traffic priority was not requested.

The aircraft was stopped straight ahead on the runway after landing and FAA maintenance pinned the gear before resuming taxi to the FAA ramp.

Phase of Flight:

Flight Phase at Start of Event: Initial Climb

Cause

Narrative:

Maintenance later reported that two proximity sensors related to nose gear retraction were defective.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Narrative:

No suggestions.

Deidentified Crewmembers Analyst SSE Report 466

Overview:

Processing:

Status: Closed

ID: 466

Date/Time When Event Occurred: Tue, 15 Feb 2011 16:00 Z

Local Time When Event Occurred: 10:00

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 17 Feb 2011 17:00 Z

Submission Date/Time: Thu, 17 Feb 2011 17:00 Z

Source: Web Submission

Debrief Narrative: Performed Inspection check of main oil filter contamination and chip detector circuit completion. 8A 1-13 A-d pgs 211-213 and 16 A-C IAW Pratt & Whitney MM 79-20-02. Must be re-checked after 10 hrs and then at 50 hrs. (Work accomplished by Max Crail of Standord Aero CRS6NR400Y KOMA 02-21-11)

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N81

Tail Number: N81

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Narrative:

DURING APPROACH TO KEARNY, NE (KEAR) RIGHT ENGINE CHIP DETECTOR LIGHT ILLUMINATED FOR 15-20 SECONDS THEN EXTINGUISHED. AIRCRAFT WAS CONDUCTING A FLIGHT INSPECTION APPROACH TO A TAILWIND RUNWAY AND A MISSED APPROACH WAS EXECUTED. THE EMERGENCY/ABNORMAL CHECKLIST WAS CONSULTED AND THE PROCEDURE WAS FOLLOWED. ALL OTHER ENGINE PARAMETERS WERE MONITORED AND INDICATED NORMAL. CREW ELECTED TO DIVERT TO OMAHA, NE (KOMA) WHERE SUITABLE MAINTENANCE WAS AVAILABLE.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

KOMA MAINTENANCE DISCOVERED SIGNIFICANT METAL DEBRIS ON FILTER SCREEN AND CHIP DETECTOR. SUBSEQUENT ENGINE RUN SHOWED ENGINE PRODUCING MORE METAL DEBRIS. AIRCRAFT GROUNDED PENDING FURTHER INVESTIGATION.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Executed Missed Approach: Yes

Flight Status after Event:

Diversion: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 464

Overview:

Processing:

Status: Closed

ID: 464

Date/Time When Event Occurred: Tue, 15 Feb 2011 04:34 Z

Local Time When Event Occurred: 22:34

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 17 Feb 2011 01:10 Z

Submission Date/Time: Thu, 17 Feb 2011 01:10 Z

Source: Web Submission

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N74

Tail Number: N74

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

Working within Chicago Class B airspace, VFR at 2500' MSL. After completing an inspection on O'Hare (KORD) Rwy 09L ILS, we were cleared to proceed to a 10-mile final for Midway (KMDW) Rwy 13C, an extended (about 7 mile) right base/dogleg to final. The east-heading placed us on the extended departure path for KORD Rwy 22L, coming toward us and starting a climbing left turn toward the east. SIC queried Chicago Approach. Approach pointed out the conflict and questioned why the SAS Airbus 340 was turning east.

Before the TCAS could alert, PIC started a descending avoidance maneuver (from 2500 MSL to 1800 MSL) with the SAS aircraft in a climbing left turn, belly toward us. We received a Traffic Alert, but no Resolution Advisory on TCAS during the avoidance maneuver. Closest point was about 0.5 mile, with 500' vertical separation. Approach apologized and said the SAS had us in sight during takeoff. We turned final at KMDW and continued with the flight check.

NOTE: During the pre-inspection telecon with Elgin TSOC, Chicago Approach, ORD Tower, and MDW Tower, PIC was told by AT supervisors that ORD would be using only Rwy 28 for departures and only Rwy 14R for arrivals during the inspection. A departure off of 22L was unexpected.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Unknown. Crew did not call tower and/or approach after sortie.

Detection

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Took Evasive Action: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Narrative:

Better communication between approach and tower.

Deidentified Crewmembers Analyst SSE Report 460

Overview:

Processing:

Status: Closed

ID: 460

Date/Time When Event Occurred: Fri, 11 Feb 2011 15:00 Z

Local Time When Event Occurred: 09:00

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 11 Feb 2011 20:36 Z

Submission Date/Time: Fri, 11 Feb 2011 20:36 Z

Source: Web Submission

Debrief Narrative: FOUND NOSE DOWN LOCK MICRO SWITCH BAD REMOVED AND REPLACED SWITCH IAW 4109.2 CHAP 32, CYCLIED GEAR SEVERAL TIMES OPS CHECKED GOOD. NOTE: Repair accomplished in OKC.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N86

Tail Number: N86

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

Crew: PIC - Brett VanMeter SIC - Robert Lewis MS - Brad Elliott

Mission was a Segment 1 Mission Training sortie for Lewis in day, VFR conditions. Crew flew fom OKC to RCE and completed two uneventful low approaches simulating a PAPI commissioning. While maneuvering for another approach, the crew lowered the landing gear. Both main gear indications were "down and locked." The nose indicator did not illuminate, the nose door open light remained illuminated and the aircraft buffeted indicating the nose doors were open. The light in the gear handle was not illuminated. The crew aborted the approach, climbed and held in VFR conditions.

The crew discussed the situation and attempted to lower the flaps beyond 30 degrees to see if the warning horn sounded. This was done, and the warning horn did activate. With conflicting indications, the crew used the SAT phone to contact FAA maintenance personnel. The crew was told that a faulty gear switch was suspected and that the one indication indicating that the gear was down and locked (the light in the handle) was powered by a separate gear switch. The crew contacted the Standards Team CL-601 subject matter expert. After he reviewed aircraft manuals and consulted with SimuFlight systems training personnel, he arrived at the same conclusion.

The crew performed a fly-by so tower personnel and FAA maintenance personnel on the ground could observe whether or not the nose gear appeared to be down and locked. Both groups indicated that the gear appeared to be down. The crew returned to the holding pattern to reduce the fuel load, coordinate with ATC personnel and brief crew actions prior to landing. Once the coordination was complete, all applicable checklists were completed and the pre-determined fuel load was reached the crew declared an emergency with ATC and performed an uneventful visual landing on runway 17R at KOKC. The crew stopped and shutdown the aircraft on the runway. FAA maintenance personnel pinned the landing gear and towed the aircraft to the hangar.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

A landing gear switch malfunctioned.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes
Reaction
Flight Crew:
Executed Missed Approach: Yes
Flight Status after Event:
Planned Emergency Landing: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 459

Overview:
Processing:
Status: Closed
ID: 459
Date/Time When Event Occurred: Thu, 03 Feb 2011 22:50 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Fri, 04 Feb 2011 15:57 Z
Submission Date/Time: Fri, 04 Feb 2011 15:58 Z
Source: Paper Submission
Debrief Narrative: Found RT bleed air pressure switch to be weak. also found hole in EVA tube in RT eng nacelle inboard side. Replaced switch and tube section system ops checked good T.I. 4128.2 Chapter 26 Part installed 90-380002-3 sn 20424
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N84
Tail Number: N84
Aircraft Type: BE-300
Narrative:
RH bleed light on passing FL 230 for FL 250. Ran checklist. Diverted to DLH.
Phase of Flight:
Flight Phase at Start of Event: Climb
Cause
Narrative:
-
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Status after Event:
Diversion: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 458

Overview:
Processing:
Status: Closed
ID: 458
Date/Time When Event Occurred: Thu, 03 Feb 2011 21:00 Z
Local Time When Event Occurred: 15:00
Viewer Accessible: Yes
Initial Notification Date/Time: Thu, 03 Feb 2011 22:54 Z

Submission Date/Time: Thu, 03 Feb 2011 22:54 Z

Source: Web Submission

Debrief Narrative: INSTALLED LH AILERON TAB WITH CORRECT P/N ATTACHING HARDWARE IAW TI4128.2. TRAVEL CHECK SATISFACTORY IAW TI4128.2, CH27-10-00, PG 218 STEP E.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N75

Tail Number: N75

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

This was an acceptance flight following Pro Line 21 and AFIS modification. A maintenance technician was onboard seated at the Mission Specialist workstation. About 1 hour into flight, the PNF noted and verbalized a momentary Aileron mistrim annunciation. About the same time, the maintenance technician noted and verbalized that the left aileron trim tab was partially detached from the aircraft. The PF had also noted some concern about behavior of the aileron trim feel prior to the trim tab detaching. An emergency was declared. Crew elected to leave flaps in existing configuration and complete a no flap landing. The gear was lowered and a controllability check was accomplished to Vref -10. Subsequent no-flap approach and landing was uneventful.

Additional aircraft malfunctions were present at the time of this event which contributed to taking the conservative action to declare an emergency. The pitot-static system was causing an alert for altimetry mismatch, the stall warning system was inoperative, and the pressurization system was malfunctioning.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Unknown

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Cabin Crew: Yes

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Declared Emergency with ATC: Yes

Landed in Emergency Condition: Yes

Flight Status after Event:

Planned Emergency Landing: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 457

Overview:

Processing:

Status: Closed

ID: 457

Date/Time When Event Occurred: Thu, 03 Feb 2011 15:00 Z

Local Time When Event Occurred: 10:00

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 03 Feb 2011 19:59 Z

Submission Date/Time: Thu, 03 Feb 2011 20:29 Z

Source: Web Submission

Debrief Narrative: FOUND SHRADDER VALVE ON ACCUMILATOR LEAKING AT BASE DEPLEATING THE BOTTLE. REMOVED AND REPLACED SHRADDER VALVE. SERVICED ACCUMILATOR, OPS CHECK GOOD IAW TI4128.2 CHAPTER 32-30. NO LEAKS NOTED.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N76

Tail Number: N76

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

Upon preparing for a ROC check at Lawrenceville, VA VN231 lowered the landing gear and no audible sound was heard nor were any lights indicated in the gear handle or on the position lights. In order to confirm the abnormal indication, the flaps were lowered to the 'full' position and the landing gear horn sounded. This indicated the gear was indeed not in the correct 'down' position. While completing the Abnormal Checklist it was noted that the landing gear C/B was popped. VN231 chose to divert back to ACY at a speed of 184KTS just in case the gear lowered on its own while enroute. Upon reaching ACY Appch, an emergency was declared, the abnormal checklist was reviewed, the landing gear was manually lowered and a correct gear down and locked indication was obtained. The gear was visually confirmed down by ACY tower. After landing, the aircraft was towed back to the hanger.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

This aircraft has had the same issue in the recent past. This aircraft is old and frail.

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Changed Configuration-Flaps/Trim: Yes

Contacted Operations: Yes

Flight Status after Event:

Precautionary Landing: Yes

Diversion: Yes

Suggestions

Narrative:

No constructive comments regarding this repeat aircraft malfunction are provided.

As a side note: While contacting the FICO via SFO ARINC it took an inordinate amount of time for the SFO operator to reach the ACY FICO desk due to the 'new' phone system in the FICO. Not only is the FICO system aggravating for end users it caused N76 a delay in providing the FICO necessary safety information in a timely manner. It is requested that Management revisit the viability of the FICO phone system as the present switchboard is a contributing factor in a reasonable safety matrix.

Deidentified Crewmembers Analyst SSE Report 455

Overview:

Processing:

Status: Closed

ID: 455

Date/Time When Event Occurred: Fri, 28 Jan 2011 18:45 Z

Local Time When Event Occurred: 12:45

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 28 Jan 2011 21:19 Z

Submission Date/Time: Fri, 28 Jan 2011 21:19 Z

Source: Web Submission

Debrief Narrative: REPAIRED HOLE IN EVA TUBING IN LEFT WING BY SPLICING TUBE IAW TI4128.2 CH 26. OPERATIONAL CHECK DUE. OPS CHECKED L & R BLEED AIR WARNING SYSTEM IAW T.I. 4128.2 CHAP 26-11-00, OPS AND LEAK CHECKED GOOD. NOTE: AFTER COMPLETION OF THE REPAIR, INDICATIONS ARE THAT THE DESIGN OF THE BLEED AIR OVERHEAT SENSING SYSTEM PERFORMED AS REQUIRED.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N75

Tail Number: N75

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

Left bleed air fail light illuminated 4-5 minutes after takeoff. The immediate action step was taken to turn the left bleed air off. The AFM emergency checklist was referenced. Instrument and visual indication of the left engine were normal. Subsequent approach and landing were uneventful.

Phase of Flight:

Flight Phase at Start of Event: Initial Climb

Cause

Narrative:

Unknown; however this was the first flight after extended down time on the aircraft.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Maintenance: Yes

Flight Status after Event:

Air Turnback: Yes

Suggestions

Narrative:

If the event was found to be a false indication, suggest additional checks of EVA tubing during the Pro Line 21 and AFIS installation. This happened with the previous aircraft as well.

Also, suggest adding selection of "Enhanced 300" to the aircraft type options in this form and removing the Hawker.

Deidentified Crewmembers Analyst SSE Report 454

Overview:

Processing:

Status: Closed

ID: 454

Date/Time When Event Occurred: Thu, 20 Jan 2011 21:48 Z

Local Time When Event Occurred: 16:48

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 21 Jan 2011 14:11 Z

Submission Date/Time: Fri, 21 Jan 2011 14:11 Z

Source: Web Submission

Debrief Narrative: Found right main gear down green light bulb bad. Installed new GE327 bulb. Jacked acft and performed MLG retraction IAW Beech 300 MM Ch 32-30-00. Ops checked good. Scott Eveschuk, KSRQ, 1/21/11, Westcoast Aviation.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N71

Tail Number: N71

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

After being cleared for a visual approach to a full stop landing at Sarasota, FL (KSRQ), the landing gear was extended while on a downwind (flaps were in approach position). The landing gear appeared to extend normally; however, the right main gear indicated unsafe (green down and locked light was NOT illuminated). ATC was advised of our intention to hold west of the airport in order to utilize the "Landing Gear Unsafe Indication" abnormal checklist, and we were cleared as requested. The checklist directed use of the "Landing Gear Manual Extension" checklist, which was completed. We declared an emergency and requested crash/fire/rescue equipment. We requested and received clearance for a fly-by, and the tower advised that the right main landing gear appeared to be "down and in place". An uneventful landing followed. The aircraft was shut down, secured, and towed off the taxiway.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Malfunction of the indication system.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Declared Emergency with ATC: Yes

Contacted ATC: Yes

Flight Status after Event:

Planned Emergency Landing: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 452

Overview:

Processing:

Status: Closed

ID: 452

Date/Time When Event Occurred: Tue, 04 Jan 2011 14:45 Z

Local Time When Event Occurred: 09:45

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 04 Jan 2011 17:39 Z

Submission Date/Time: Tue, 04 Jan 2011 17:39 Z

Source: Web Submission

Debrief Narrative: 1st repair - Found adel clamp chaffing on bus w1 of tripple/center bus. Replaced adel clamp and repositioned clamp to prevent chaffing. Applied power to tripple/center bus, no defect noted.

2nd repair - Troubleshoot system & found amp/volt indicator to be bad. Replaced indicator, ran aircraft & ops checked good. After an investigation of several fleet aircraft, the possibility existed for the condition to be repeated and Maintenance Alert Directive 11-01R1 was issued to replace the clamp throughout the Beech300 fleet.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N74

Tail Number: N74

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

At cruise PNF noticed "nervous" needles on loadmeters, voltmeter, and ammeter. Upon investigation, noticed ammeter at 10 amps discharge, and voltage at 26.5. Load meters slightly elevated at 50%, but paralleled. Power reduction returned ammeter toward zero or positive indication, and voltmeter to 27.5+/- . No annunciator lights illuminated. No abnormal or emergency checklist addressed issue. Contacted FICO maintenance and returned to BTL.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Maintenance found adel clamp in proximity to, and shorting out center bus distribution bar, below floor of main cabin, forward of spar. On N74, there is a large plug type connector that was forcing the adel clamp toward the center bus.

Detection

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Flight Status after Event:

Air Turnback: Yes

Diversion: Yes

Suggestions

Narrative:

Check all BE300 aircraft for this condition, and rewire as necessary to move the plug type connector that was forcing the adel clamp toward the center bus, to a benign location.

Deidentified Crewmembers Analyst SSE Report 451

Overview:

Processing:

Status: Closed

ID: 451

Date/Time When Event Occurred: Wed, 29 Dec 2010 15:00 Z

Local Time When Event Occurred: 09:00

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 30 Dec 2010 13:48 Z

Submission Date/Time: Thu, 30 Dec 2010 13:48 Z

Source: Web Submission

Debrief Narrative: Found discharge wire at bottle coming out of ring terminal. Installed new ring terminal and connected to fire bottle. Discharge light does not come on. Fire test check satisfactory at this time.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N71

Tail Number: N71

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

While beginning a RNAV (GPS) ROC inspection at Marks/Selfs, MS [KMMS], prior to descending to inspection altitude, the Left Engine Fire Bottle Discharge light illuminated. VFR approach was terminated and aircraft configuration returned to cruise settings. Memphis Approach Control was contacted and a diversion to KMEM, closest location with contract maintenance, was initiated. The Left Engine Fire Bottle Discharge light remained illuminated for approximately five (5) minutes en route KMEM. During cruise and approach to KMEM, the light again illuminated three (3) additional times for durations of 30 to 90 seconds each. MEM Approach Control was asked to telephone the FICO and advise of diversion and reason. Unsure of the aircraft system status, PIC requested and was granted Priority Handling status. An In-Flight Emergency was not declared. Clearance to KMEM was gained and the aircraft landed without further incident. Upon termination at KMEM, FICO OPS, ATL FIFO Safety Officer, and FICO Maintenance were contacted. FICO Maintenance coordinated local contract maintenance assistance. Post-contractor maintenance, aircraft was released for return to homestation [KFTY].

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Local contract maintenance found a loose wire in the Fire Bottle Squib connector.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Changed Configuration-Flaps/Trim: Yes

Contacted ATC: Yes

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Executed Go Around: Yes

Flight Status after Event:

Diversion-Other Alternate: Yes

Air Turnback: Yes

Diversion: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 450

Overview:

Processing:

Status: Closed

ID: 450

Date/Time When Event Occurred: Thu, 23 Dec 2010 16:20 Z

Local Time When Event Occurred: 11:20

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 23 Dec 2010 17:59 Z

Submission Date/Time: Thu, 23 Dec 2010 17:59 Z

Source: Web Submission

Debrief Narrative: No Corrective action. There is ILM data to suggest a repair was not required or accomplished.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N71

Tail Number: N71

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

At 6000MSL over Covington, GA [K9A1] on TURBO 8 Arrival into KFTY, ATL APP CON [126.97] issued a VFR traffic point-out at "...2 O'clock and four miles, VFR traffic at 5500...". Crew began searching the area without TCAS target indication out to ten [10] miles. Approximately two [2] minutes after ATC notification, a red "RA" target resolution [-500] with audio "Climb" warning was received. Pilot Flying immediately executed a maximum power/maximum climb angle evasive maneuver, climbing to 6750MSL before the TCAS warning ceased. ATC was notified of TCAS warning and altitude deviation before returning to assigned altitude. VFR traffic was never seen by flight crew and upon reaching 6750MSL, N71 TCAS again failed to show any aircraft within ten [10] nautical miles. Flight continued along assigned routine to KFTY without further incident.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Unknown.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Returned to Assigned Altitude: Yes

Took Evasive Action: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 449

Overview:

Processing:

Status: Closed

ID: 449

Date/Time When Event Occurred: Tue, 21 Dec 2010 14:45 Z

Local Time When Event Occurred: 08:45

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 21 Dec 2010 22:01 Z

Submission Date/Time: Tue, 21 Dec 2010 22:01 Z

Source: Web Submission

Debrief Narrative: During T/S of LT engine fire extinguishing, found bayonette connection loose & damaged. repaired same, system ops checked GD per TI 4128.5 W/D 26-21-01. Inspected Lt engine bleed light on engine run, CND. OK for service

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N71

Tail Number: N71

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

Approximately forty-five [45] minutes after takeoff, during PAPI commissioning - in down-wind at remote airfield [K11A] - left engine fire extinguisher 'Discharge' light illuminated for five [5] seconds and Left Bleed Air Fail light flickered without a Master Warning or Caution light illumination. Inspection terminated and aircraft diverted to nearest suitable airfield [KDHN]. En route landing airfield, a second identical incident occurred. Landing and shutdown were accomplished without further incident.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Unknown at this time; ATL Maintenance personnel were dispatched from KFTY to KDHN to examine N71 in an attempt to determine cause.

Detection

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Flight Status after Event:

Precautionary Landing: Yes

Diversion: Yes

Flight Cancellation: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 448

Overview:

Processing:

Status: Closed

ID: 448

Date/Time When Event Occurred: Mon, 20 Dec 2010 16:55 Z

Local Time When Event Occurred: 10:55

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 20 Dec 2010 21:27 Z

Submission Date/Time: Mon, 20 Dec 2010 21:27 Z

Source: Web Submission

Debrief Narrative: REMOVED AND REPLACED DUCT ON THE R\H HEAT EXCHANGER AND INSTALLED NEW BLEED AIR TUBING IAW TI. 4128.2 CH OPS AND LEAK CHECKED GOOD

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N84

Tail Number: N84

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

While climbing through FL 190, 40 NM south of KOKC, R BL AIR FAIL light and Master WARNING annunciator illuminated. The crew accomplished the emergency checklist and the PNF alerted ATC of the problem. ATC cleared FLC84 direct to KOKC with a decent clearance to 11,000 at the aircrew's request. An uneventful landing was accomplished at KOKC and the aircraft was turned over to maintenance. The aircrew did not declare an emergency.

Phase of Flight:

Flight Phase at Start of Event: Climb

Cause

Narrative:

OKC maintenance is investigating to determine the cause.

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Operated in Degraded Conditions: Yes

Flight Status after Event:

Air Turnback: Yes

Diversion: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 447

Overview:

Processing:

Status: Closed

ID: 447

Date/Time When Event Occurred: Fri, 17 Dec 2010 13:30 Z

Local Time When Event Occurred: 07:30

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 17 Dec 2010 16:59 Z

Submission Date/Time: Fri, 17 Dec 2010 17:05 Z

Source: Web Submission

Debrief Narrative: Removed and replaced damaged R/H nose gear door assy and inspected surrounding area IAW TI 4109.2 Chpt 32.

Performed three nose gear extension and retraction checks with no defects noted. Dave Osborne, RU3A796U, KBIS, 12/17/10. RII C/W by Roger Salinas

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N85

Tail Number: N85

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Off Duty Pilot

Narrative:

All info relating to this event was supplied by Executive Air (EA) maintenance manager. No crew were present at the event, nor was the aircraft being moved at the request of any AVN crew member. Initial crew notification was through a phone call to copilot by Executive Air.

Times are estimated.

Aircraft was being moved back into hanger after being removed to allow removal of other aircraft from hanger. An EA maintenance person was in the process of connecting tow bar to aircraft and/or tug, and was found pinned between tug and nosewheel gear doors unconscious. A bystander saw the EA person in distress, removed the tug, and provided aid.

Note: The tug was found in gear by the bystander.

Phase of Flight:

Flight Phase at Start of Event: Non-Flight

Cause

Narrative:

Unknown.

Detection

How Event Detected:

Maintenance Personnel: Yes

Reaction

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 453

Overview:

Processing:

Status: Closed

ID: 453

Date/Time When Event Occurred: Fri, 10 Dec 2010 15:30 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 20 Dec 2010 14:34 Z

Submission Date/Time: Wed, 05 Jan 2011 17:25 Z

Source: Paper Submission

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N56

Tail Number: N56

Aircraft Type: LR-60

Narrative:

Checking the NDB approach to KSPF; Upon descent came within 200 feet of paraglider. Pulled up abruptly and powered up to avoid a collision.

Phase of Flight:

Flight Phase at Start of Event: Descent

Cause

Narrative:

VFR traffic without transponder or VHF comm.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction
Flight Crew:
Took Evasive Action: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 446

Overview:
Processing:
Status: Closed
ID: 446
Date/Time When Event Occurred: Thu, 02 Dec 2010 16:30 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Thu, 09 Dec 2010 14:50 Z
Submission Date/Time: Thu, 09 Dec 2010 14:56 Z
Source: Paper Submission
Debrief Narrative: Removed left inlet side panel. No bird matter noted at left engine inlet screen. Reinstalled panel. Completed visual walk around of A/C. No other bird matter noted. Work completed by Dean Zimmer at MSP Jet Center, KMSP, 12/02/2010
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N74
Tail Number: N74
Aircraft Type: BE-300
Narrative:
On short approach to KMSP runway 30L at approximately 100 ft AGL, flew through a flock of small birds (approximately 20 to 25). Hit one on left-hand engine intake. Wrote aircraft up. KMSP mechanic cleared. Advised tower and approach.
Phase of Flight:
Flight Phase at Start of Event: Approach
Cause
Narrative:
-
Detection
How Event Detected:
Flight Crew: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Contacted ATC: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 445

Overview:
Processing:
Status: Closed
ID: 445
Date/Time When Event Occurred: Tue, 30 Nov 2010 17:30 Z
Local Time When Event Occurred: 09:30
Viewer Accessible: Yes
Initial Notification Date/Time: Tue, 30 Nov 2010 18:38 Z
Submission Date/Time: Tue, 30 Nov 2010 18:38 Z
Source: Web Submission

Debrief Narrative: Noted VGV feedback cable to FCU retaining pin rubbing up against boss fitting possibly causing restriction of movement. Repositioned pin, freedom of movement and travel checks Sat. Performed 2 subsequent engine starts with no faults noted. Work performed by Dave Osborne IAW TI 4109.2 chpt 71, RU3A796U, KOKC, 11/30/2010

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N86

Tail Number: N86

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

N86 On first start of day, right engine. Engine never completed start cycle. After started cutout, engine N2 started decreasing, it started increasing.

Engine start malfunction checklist performed.

Phase of Flight:

Flight Phase at Start of Event: Engine Start/Pushback

Cause

Narrative:

To be determined.

Detection

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

PreFlight: Yes

Reaction

Flight Crew:

Engine Shutdown: Yes

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Narrative:

As indicated by AVN300 diagnosis results.

Deidentified Crewmembers Analyst SSE Report 444

Overview:

Processing:

Status: Closed

ID: 444

Date/Time When Event Occurred: Sat, 20 Nov 2010 18:55 Z

Local Time When Event Occurred: 11:55

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 22 Nov 2010 21:34 Z

Submission Date/Time: Mon, 22 Nov 2010 21:34 Z

Source: Web Submission

Debrief Narrative: Visually inspected all accessible portions of A/C. No damage noted. Inspected flight controls for freedom of movement, no defects noted. Visually inspected interior furnishings for installation security. No defects noted. No further action taken.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N58

Tail Number: N58

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

While conducting a flight check on the PKN LOC (Aspen, CO) in conditons of light/moderate turbulence, VMC but operating under IFR, we were climbing through FL180 to start a comparability check at FL200 when a loud popping noise and a simultaneous sharp jolt was experienced by the aircraft. It was felt and heard by all three crewmembers and seemed to come through the floor of the cabin. The crew felt that we were hit by something or had lost an airframe component such as a landing gear door. No abnormal indications were noted on any aircraft system and there was no vibration or control problems. We leveled at FL180 and, after evaluating the aircraft and situation, decided to proceed back to KGJT for a precautionary landing. We requested a descent to 16000 and direct routing to KGJT. We cancelled the IFR nearing KGJT and advised ATC of our situation. No emergency was declared. We made two tower flybys, one with gear and flaps up, the other with gear and flaps at 20. The tower could see no abnormalities. After burning fuel down to landing weight a normal landing was completed. After shut down, a careful inspection was made of the aircraft visually by the crew with no apparent cause of the noise and jolt found. After a log book writeup, FICO maintenance arranged for an inspection by a mechanic with nothing found. The aircraft was returned to service and we departed back to KASE for continued work on the PKN LOC. No further problems were noted on two subsequent flights.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Unknown.

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Status after Event:

Diversion: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 443

Overview:

Processing:

Status: Closed

ID: 443

Date/Time When Event Occurred: Mon, 01 Nov 2010 01:30 Z

Local Time When Event Occurred: 11:30

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 01 Nov 2010 06:38 Z

Submission Date/Time: Mon, 01 Nov 2010 06:38 Z

Source: Web Submission

Debrief Narrative: #2 eng ops ck good IAW TI 4109.2 chap 71-00-00. Work completed by Rick Denson, RU3A796U, 11/01/10, PGUA.

Notes: Subsequent Discrepancy resulted in a fuel control change on same engine 11/1/2010

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N86

Tail Number: N86

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

On descent into Andersen AFB Guam, upon passing 16,000 right engine low oil pressure light illuminate (confirmed by tape indication) followed by the right generator going off line. N1 indication on left engine read 65% and right engine read 34%. In-flight start ignition was on for weather deviation and when power levers advance the right engine recovered. On subsequent start for maintenance on the ground the right engine stabilized at 57% for about fifteen seconds and then slowly accelerated to 67%.

Phase of Flight:

Flight Phase at Start of Event: Descent

Cause

Narrative:

TBD

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 442

Overview:

Processing:

Status: Closed

ID: 442

Date/Time When Event Occurred: Wed, 20 Oct 2010 15:30 Z

Local Time When Event Occurred: 10:30

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 21 Oct 2010 14:30 Z

Submission Date/Time: Thu, 21 Oct 2010 14:30 Z

Source: Web Submission

Debrief Narrative: REMOVED AND REPLACED #2 ENG IDG OP AND LK CK GOOD PER T.I. 4109.2 CH 24-21-00

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N85

Tail Number: N85

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

While established on an ILS Back Course to RWY 28 at KMAF about 3 miles prior to the FAF at 4500' MSL, the crew heard a loud noise accompanied by the auto pilot kicking off; immediately followed by a Master Caution Warning and two lights on the 8-10 Panel (ELEC and HYD). PF (Castro, PIC) took manual control of the airplane and broke off the approach while in VMC conditions. PNF (Snelling, SIC) contacted ATC requesting cancellation of IFR clearance for VFR with Flight Following. Crew climbed to 7500' MSL VFR and established in a VFR holding pattern while discussion and checklist were being conducted. PF re-engaged the autopilot and established a VFR hold and took over the radios. PNF opened Vol II Procedures Checklist and ran the Abnormal "Generator Off"

Checklist. After crew discussion of various options, the decision was made to fly back to KOKC, VFR with flight following at 17,500' MSL from KMAF (about 55 min of flight time). While in enroute the crew was able to start the APU and left it running just in case we lost the other generator we could quickly kick on the APU Gen for back up power. We also contacted FICO and FICO MX. ATC was notified of our intentions to fly to KOKC with "no assistance required." ILS MX was notified that the Flight Inspection would be terminated and to contact FICO for future reschedule. On return to KOKC, we had to hold for 1hr to burn down enough fuel to get below max landing weight. After landing uneventfully, mx met the aircraft and crew and was debriefed.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

The event occurred because the #2 Engine Generator failed in flight.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Executed Go Around: Yes

Operated in Degraded Conditions: Yes

Flight Status after Event:

Air Turnback: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 440

Overview:

Processing:

Status: Closed

ID: 440

Date/Time When Event Occurred: Fri, 15 Oct 2010 01:30 Z

Local Time When Event Occurred: 16:30

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 15 Oct 2010 15:26 Z

Submission Date/Time: Fri, 15 Oct 2010 15:26 Z

Source: Web Submission

Debrief Narrative: FOUND RH MLG DOWN AND LOCK SWITCH FAILS BETWEEN PINS "B" AND "S" (EXTEND CIRCUIT) WHEN SWITCH IS COLD. (OPERATES NORMALLY WHEN WARM).

REMOVED AND REPLACED RH MLG DOWN AND LOCK SWITCH IAW TI4128.2 CHAPTER 32-60-00 PAGE 9. REQUIRES CLOSE-UP AND FINAL OP CHECKS. LANDING GEAR SYSTEM OP CHECKS OK IAW TI 4128.2, CHAPTER 32.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N76

Tail Number: N76

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

While conducting an ILS-3 (flight inspection maneuver) approach to Huntington, WV, RWY12. Landing gear was selected in the down position. Crew noticed "Red" handle unsafe light and right main gear "Green" light extinguished. ATC and CFR advised. Performed landing gear abnormal checklist procedure. Landing gear extended normally and landing was uneventful.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Appears Landing Gear limit switch needs adjustment.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Changed Configuration-Flaps/Trim: Yes

Flight Status after Event:

Precautionary Landing: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 441

Overview:

Processing:

Status: Closed

ID: 441

Date/Time When Event Occurred: Thu, 07 Oct 2010 21:30 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 19 Oct 2010 16:22 Z

Submission Date/Time: Tue, 19 Oct 2010 16:28 Z

Source: Paper Submission

Debrief Narrative: Comm #3 burned out. Pulled CB CoPilots panel. Work Accomplished by Loyd's AC Maint.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N72

Tail Number: N72

Aircraft Type: BE-300

Narrative:

WHILE CONDUCTING AN ILS-1 ON THE KBFL ILS RWY 30R, STRONG ELECTRICAL FUMES (NO SMOKE) FILLED THE FUSELAGE. EXACT SOURCE COULD NOT BE DETERMINED BUT THE MS DETERMINED THE FUMES WERE EMINATING FROM HIS FLIGHT INSPECTION PANEL. THE SMOKE AND FUME ELIMINATION CHECKLIST WAS RUN WITH NO RELIEF FROM THE FUMES. AN IMMEDIATE LANDING WAS EXECUTED AT KBFL.

Cause

Narrative:

FAILURE OF VHF COMM #3

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Landed in Emergency Condition: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 439

Overview:

Processing:

Status: Closed

ID: 439

Date/Time When Event Occurred: Thu, 07 Oct 2010 19:15 Z

Local Time When Event Occurred: 14:15

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 07 Oct 2010 22:40 Z

Submission Date/Time: Thu, 07 Oct 2010 22:40 Z

Source: Web Submission

Debrief Narrative: Aircraft flown under authority of an SFP under DDL# 159. Damage to be repaired while in "C" Check

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N57

Tail Number: N57

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

While conducting the final approach portion of an LPV commissioning at KUBX, a hawk flew in front of the aircraft. The bird did drop below the front of the plane, however at the speed we were flying it was not possible to miss it.

The only damage was to the ray dome. aircraft handling and performance were not affected.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Bird activity in the area around the airdrome as usual.

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Company: Yes

Contacted Maintenance: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 438

Overview:

Processing:

Status: Closed

ID: 438

Date/Time When Event Occurred: Thu, 07 Oct 2010 12:10 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 07 Oct 2010 13:33 Z

Submission Date/Time: Thu, 07 Oct 2010 13:33 Z

Source: Web Submission

Debrief Narrative: Placed Aircraft on jacks, duplicated squawk inspected R/H down lock switch and wiring, found S506 connector loose, secured connector, operation found good on several gear retraction cycles.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N76

Tail Number: N76

Aircraft Type: BE-300

Narrative:

On flight check of KMJX VOR 6 Approach. Flaps at approach position. Selected landing gear down. Position indicators showed green for nose and left main gear, no indication on right main gear. Checked annunciator good. Selected flaps full down and received configuration warning horn. Declared an emergency with Atlantic City Approach. Followed abnormal procedures checklist "Landing Gear Unsafe Indication" followed by "Landing Gear Manual Extension". Obtained down and locked indication after manually pumping down the gear. Conducted tower fly by to verify. Tower indicated gear appeared normal. Verified that configuration warning horn did not occur with full flaps selected.

Conducted uneventful landing KACY. Stopped aircraft on taxiway. ACY MX towed to hangar.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Unknown.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Declared Emergency with ATC: Yes

Executed Missed Approach: Yes

Flight Status after Event:

Unplanned Emergency Landing: Yes

Suggestions

Narrative:

None at this time.

Deidentified Crewmembers Analyst SSE Report 434

Overview:

Processing:

Status: Closed

ID: 434

Date/Time When Event Occurred: Fri, 17 Sep 2010 06:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 17 Sep 2010 13:00 Z

Submission Date/Time: Fri, 17 Sep 2010 13:37 Z

Source: Hotline

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N85

Tail Number: N85

Aircraft Type: CL-601

Narrative:

While in an ATC assigned holding pattern at 10,000' (CROWN intersection), FLC 85 experienced a near mid-air collision with a flight of two F-16s, flight call sign "Captain Kilo", resulting in a TCAS resolution advisory, forcing FLC 85 to immediately "climb" to avoid a collision. The immediate RA "climb" required FLC 85 to climb in excess of 300' from assigned altitude. During the RA maneuver, the pilot flying also had to self initiate a left turn to avoid collision. Shortly after the commencement of the maneuvering, ATC directed FLC 85 to turn left immediately.

Further, during the climb, FLC 85 received an additional TA from an aircraft above, during the RA maneuver on Captain Kilo flight, forcing FLC 85 to stop climbing. The controlling agency was Osan Approach. After recovery back at Osan (RKSO), the Chief Air Traffic Control Officer met with the crew and advised the FLC 85 crew that the controller had been decertified as a result of the incident with possible decertification of the Watch Supervisor, pending review of RADAR data and ATC tapes.

Cause

Narrative:

-

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Took Evasive Action: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 433

Overview:

Processing:

Status: Closed

ID: 433

Date/Time When Event Occurred: Thu, 09 Sep 2010 13:15 Z

Local Time When Event Occurred: 09:15

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 09 Sep 2010 19:28 Z

Submission Date/Time: Thu, 09 Sep 2010 19:28 Z

Source: Web Submission

Debrief Narrative: REMOVED GASKET P/N 3116033-01 AND REINSTALLED ALL REMOVED COMPONENTS. LEAK CHECK AND C/W POWER ASSURANCE RUN. ALL WORK C/W REF: TO PRATT & WHITNEY MM 3034342 REV #39 DATED APR 30 2010. C/W BY DALLAS AIRMOTIVE

FROM MILVILE NJ REPAIR STATION # QT2R121L FAA SCARLETT QA

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N69

Tail Number: N69

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

N69 was notified by ATC to contact FICO Dispatch. N69 complied and was directed to immediately return to ACY FIFO due to a maintenance issue (N69 completed a "B" check 7 September, 2010).

N69 was 20nm north of HGR on an IFR flight plan between itinerary facilities. Approximate time was 1315Z.

The following identifies who was involved and provides background information that culminated in N69 being diverted due to Maintenance issues:

Dallas Airmotive (the entity that completed the hotsection inspection/repairs) contacted JSSI (a company AVN regularly uses to source out Mx) who in turn contacted AVN Mx QC [date time unknown] to a maintenance action that occurred during their repairs on N69 the previous week. AVN Mx QC determined that the matter was a safety of flight issue and subsequently contacted FICO Mx in order to have N69 grounded. FICO Mx in turn notified the ACY Dispatcher of the situation. N69 had already been dispatched and was airborne.

FICO Dispatch contacted multiple ATC agencies in order to contact N69 and have it return to ACY.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

[My information regarding this "double gasket" issue is word of mouth and not first hand knowledge]. The reason N69 was directed by FICO dispatch to immediately return to base appears to be that the contract maintainer (Dallas Airmotive) incorrectly installed a gasket during engine work last week such that two (2) gaskets were installed on a particular engine section vice one (1). This installation error was likely not malicious rather due to ignorance, complacency or incompetence.

Detection

How Event Detected:

ATC: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Company: Yes

Flight Status after Event:

Diversion: Yes

Suggestions

Narrative:

AVN maintenance should consider having FAA QA personnel constantly oversee contract maintainers when contract maintenance is accomplished at a FIFO.

AVN Mx QA/JSSI should investigate Dallas Airmotive's level of competence and determine whether to continue to use their services in the future.

Deidentified Crewmembers Analyst SSE Report 430

Overview:

Processing:

Status: Closed

ID: 430

Date/Time When Event Occurred: Mon, 23 Aug 2010 17:30 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 23 Aug 2010 18:07 Z

Submission Date/Time: Mon, 23 Aug 2010 18:13 Z

Source: Hotline

Debrief Narrative: FOUND PROP SHAFT SEAL CUT. REMOVED UPPER AND LOWER FWD COWLING, REMOVED PROP IAW T.I. 4128.2 CHAP 61-10-00. REMOVED AND REPLACED PROP SHAFT SEAL IAW T.I. 4128.7-2 CHAP 72-10-00, REINSTALLED PROP IAW T.I. 4125.2 CHAP 61-10-00. REINSTALLED FWD UPPER AND LOWER COWLING, SERVICE ENGINE WITH OIL TO PROPER LEVEL (ADDED 4 QTS) PROP SHAFT SEAL LEAK CHECKED GOOD DURING ENGINE RUNS.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N81

Tail Number: N81

Aircraft Type: BE-300

Narrative:

In cruise at 17,000 ft between Ardmore, OK and Dallas Love Field; Mission Specialist noticed oil coming out of number 2 engine. Oil pressure on number 2 was fluctuating below 60 psi. Engine was shutdown and crew landed in Ardmore, OK.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

-

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Landed in Emergency Condition: Yes

Engine Shutdown: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 429

Overview:

Processing:

Status: Closed

ID: 429

Date/Time When Event Occurred: Sun, 22 Aug 2010 22:30 Z

Local Time When Event Occurred: 08:30

Viewer Accessible: Yes

Initial Notification Date/Time: Sun, 22 Aug 2010 23:24 Z

Submission Date/Time: Sun, 22 Aug 2010 23:24 Z

Source: Web Submission

Debrief Narrative: Open eng cowl, inspected fuel control & starter. Checked eng throttle rigging, all checked good. Closed eng cowling and restarted eng. Start was normal. Ops ck good IAW TI 4109.2. Work completed by Roger Salinas, RU3A796U, PHNL, 8/16/10.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N85

Tail Number: N85

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

While starting #1 engine at PGUA following normal start on #2 engine, engine rolled back and shutdown immediately following starter cutout, with the thrust lever in the idle position. Start malfunction checklist was followed, disengaging ignition & fuel pumps. Starter was not re-engaged to clear engine because ITT was below 350 degrees C. Event occurred as exactly the same as SSE submitted on 16 Aug 10.

Phase of Flight:

Flight Phase at Start of Event: Engine Start/Pushback

Cause

Narrative:

Unknown. Mx is inspecting fuel control and variable guide vanes.

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

PreFlight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Engine Shutdown: Yes

Flight Status after Event:

Flight Cancellation: Yes

Flight Delay: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 428

Overview:

Processing:

Status: Closed

ID: 428

Date/Time When Event Occurred: Mon, 16 Aug 2010 19:25 Z

Local Time When Event Occurred: 09:25

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 16 Aug 2010 20:13 Z

Submission Date/Time: Mon, 16 Aug 2010 20:13 Z

Source: Web Submission

Debrief Narrative: -- Open eng cowl, inspected fuel control & starter. Checked eng throttle rigging, all checked good. Closed eng cowling and restarted eng. Start was normal. Ops ck good IAW TI 4109.2. Work completed by Roger Salinas, RU3A796U, PHNL, 8/16/10.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N85

Tail Number: N85

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

While starting #1 engine at PHNL following normal start on #2 engine, engine rolled back and shutdown immediately following starter cutout, with the thrust lever in the idle position. Start malfunction checklist was followed, disengaging ignition & fuel pumps. Starter was not re-engaged to clear engine because ITT was below 350 degrees C.

Phase of Flight:

Flight Phase at Start of Event: Engine Start/Pushback

Cause

Narrative:

Unknow cause.

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

PreFlight: Yes

Reaction

Flight Crew:

Contacted Maintenance: Yes

Engine Shutdown: Yes

Flight Status after Event:

Flight Delay: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 426

Overview:

Processing:

Status: Closed

ID: 426

Date/Time When Event Occurred: Fri, 13 Aug 2010 17:37 Z

Local Time When Event Occurred: 13:37

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 13 Aug 2010 20:16 Z

Submission Date/Time: Fri, 13 Aug 2010 20:16 Z

Source: Web Submission

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N69

Tail Number: N69

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

N69 was conducting ILS-1 flight inspection 10nm arcing maneuver on MQS Coatesville, Chester County, PA ILS or LOC 29. Weather conditions 40 OVC 20 nm visibility. Heavy and significant traffic from N57 New Garden, OQN Brandywine, MQS Chester County and PHL International. N69 was monitoring PHL Approach, MQS Facility Mx, N57 and OQN frequencies depending on its location on the 10nm arc. VN007 took evasive action and called traffic simultaneously decreasing power and lowering aircraft attitude. A Cessna 152 aircraft was spotted at N69 left 10 o'clock position at the same altitude. If no actions were taken N69 would have impacted the other aircraft within approximately two (2) seconds. PHL Approach did not notify N69 as he was swamped with traffic. He noted the aircraft was not squaking altitude. N69 continued PM on ILS or LOC 29 Chester County and returned to ACY.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

The event occurred due to congested airspace and the Cessna 152 failing to activate its altitude encoder.

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Corrected Pitch/Power: Yes

Took Evasive Action: Yes

Suggestions

Narrative:

All crewmembers need to continuously keep an active outside scan while in congested airspace.

Deidentified Crewmembers Analyst SSE Report 427

Overview:

Processing:

Status: Closed

ID: 427

Date/Time When Event Occurred: Wed, 11 Aug 2010 02:48 Z

Local Time When Event Occurred: 22:48

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 12 Aug 2010 07:46 Z

Submission Date/Time: Mon, 16 Aug 2010 15:02 Z

Source: Paper Submission

Debrief Narrative: Airport manager and Georgia Dept of Transportation were advised. They are clearing additional brush to discourage deer. <Stuckert>

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N70

Tail Number: N70

Aircraft Type: BE-300

Narrative:

We pulled out of the chocks at 0248Z/2248L for night work at KATL. KFTY was using RWY 8 and because traffic had been sparse, we requested a back-taxi along RWY 26 to make sure there were no deer on or near the runway. After completing a run-up, we back-taxed along RWY 26 with clearance from tower to turn around and take-off on RWY 8 once we reached the other end.

As we pulled up along Taxi-Way Juliet, we spotted two deer standing about fifty [50] feet north of 8/26 and west of Juliet where the taxi-way crosses 8/26 for 9/27 and the maintenance run-up area. With tower's permission, we executed a 360 degree turn in an attempt to scare the deer back to the fence line and wooded area north of 8/26 [near where Juliet meets 9/27]. The deer did not move and continued to graze just north of the active.

We asked the tower to dispatch a vehicle to scare the deer back into the wooded area and away from the runway. It took a ground vehicle from Hill Aircraft, with headlights on high beam, making a close approach to the deer before they moved [slowly according to the ground vehicle personnel] into the wooded area north of the runway and along the fence line.

It appears the deer are not scared of the aircraft noise or lights...and the fence is not keeping them off the airfield.

We were delayed approximately fifteen [15] minutes; however, we felt better afterward knowing, at least temporarily, the deer were not close to the runway.

Upon return to KFTY, we requested another sweep by ground vehicle prior to landing. No deer were reported and we landed without incident.

Event occurred again with 4 deer, at night, on the morning of 08/13.

Phase of Flight:

Flight Phase at Start of Event: Taxi-Out

Cause

Narrative:

-

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

Taxi: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 425

Overview:

Processing:

Status: Closed

ID: 425

Date/Time When Event Occurred: Tue, 10 Aug 2010 15:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 10 Aug 2010 21:25 Z

Submission Date/Time: Tue, 10 Aug 2010 21:28 Z

Source: Paper Submission

Debrief Narrative: REPLACED TRIMBLE PROCESSOR -- INSPECTED CKT BKR PANEL AND RELOADED DATABASE EAST/WEST.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N74

Tail Number: N74

Aircraft Type: BE-300

Narrative:

On taxi out, Trimble GPS circuit breaker (3 amp/28 volts, aft of M.S.) popped with some fumes. Shut down on taxiway and towed back to FBO ramp.

Phase of Flight:

Flight Phase at Start of Event: Taxi-Out

Cause

Narrative:

-

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

Taxi: Yes

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 421

Overview:

Processing:

Status: Closed

ID: 421

Date/Time When Event Occurred: Fri, 23 Jul 2010 16:10 Z

Local Time When Event Occurred: 11:15

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 28 Jul 2010 13:34 Z

Submission Date/Time: Wed, 28 Jul 2010 13:34 Z

Source: Web Submission

Debrief Narrative: -- Performed functional test of the rudder/yaw system IAW TI4129.2 chapt 27-20-00 & 27-21-00. Checked rudder control cables for binding or obstructions, system all checked good. Work completed by Roger Salinas, RU3A796U, KOKC, 7/23/10.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N87

Tail Number: N87

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

Two uncommanded abrupt right rudder inputs. Autopilot ON. Yaw Damp ON. Aircraft climbing through 8000' 250 kts. 2nd event 11000' 250 kts. No servo monitor light illuminated. No indication of jam rudder. All three hydraulic system pressures NORMAL.

We initiated a phone patch with FICO, FICO MX and Chief Pilot. We discussed various options and determined safest plan was to recover into Omaha (our planned destination). Flight time to Omaha was less than 20 min. We kept the jet below FL210, 250 kts. Landed uneventfully.

Phase of Flight:

Flight Phase at Start of Event: Climb

Cause

Narrative:

Suspect possible yaw damp problems.

Detection

How Event Detected:

Flight Crew: Yes

Reaction

Flight Crew:

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 424

Overview:

Processing:

Status: Closed

ID: 424

Date/Time When Event Occurred: Wed, 14 Jul 2010 19:30 Z

Local Time When Event Occurred: 14:30

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 03 Aug 2010 12:38 Z

Submission Date/Time: Tue, 03 Aug 2010 12:38 Z

Source: Web Submission

Debrief Narrative: -- Inspected bleed air sense line in left wing and nacelle. Replaced 28" of EVA tubing behind left intercooler. Removed left bleed air fail switch , cleaned and re installed. Operational check good on ground. Work performed by Executive Beech KSUS,

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N67

Tail Number: N67

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

Cruise flight, from FI at KFWC to RON location KSUS, 6000' MSL, 200 KIAS, VMC, stable power setting. "L BL AIR FAIL" annunciator illuminated. Crew accomplished memory item "Bleed-Air Valve -- PNEU & ENVIR OFF>" Monitored engine instruments remainder of flight. Landed and shut down uneventfully.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Executive Beechcraft at KSUS found a stringer had chafed through EVA tubing. A 20" section was replaced.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Status after Event:

No Disruption: Yes

Suggestions

Narrative:

Deidentified Crewmembers Analyst SSE Report 420

Overview:

Processing:

Status: Closed

ID: 420

Date/Time When Event Occurred: Sat, 10 Jul 2010 18:45 Z

Local Time When Event Occurred: 13:45

Viewer Accessible: Yes

Initial Notification Date/Time: Sat, 10 Jul 2010 22:08 Z

Submission Date/Time: Sat, 10 Jul 2010 22:08 Z

Source: Web Submission

Debrief Narrative: Replaced bleed air duct sensor in LT stub wing per TI 4109.2 Chapter 36. LT wing bleed Air duct system ops checked satisfactory.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N87

Tail Number: N87

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

While setting up for ILS1 (RWY 36) maneuver under visual flight rules 10 miles east of KEAR at 3,600 MSL (1,500 AGL) and 180 kias, Bleed Duct Fail annunciator and left 14th stage bleed duct failure illuminated. PIC (PNF) accomplished immediate action item and then referenced Emergency checklist. Duct fail lights remain illuminated and left 14th stage bleed valve indicated closed after 30 seconds. IAW checklist #1 thrust lever was retarded to idle and duct fail lights still remain illuminated. PF initiated a climb to 4,500 MSL with #1 engine at idle maintaining 180 kias and remaining on the 10 NM orbit. After coordination amongst the crew, the PIC directed a precautionary landing be made at KEAR. ATC (Minneapolis center) was notified and PF broke the orbit off or a left downwind to RWY18. PNF accomplished all normal checklists and PF accomplished uneventful planned overweight landing (39,600 lbs).

Phase of Flight:

Flight Phase at Start of Event: Holding

Cause

Narrative:

TBD by mx

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Flight Status after Event:

Precautionary Landing: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 419

Overview:

Processing:

Status: Closed

ID: 419

Date/Time When Event Occurred: Wed, 07 Jul 2010 20:20 Z

Local Time When Event Occurred: 15:20

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 07 Jul 2010 23:43 Z

Submission Date/Time: Wed, 07 Jul 2010 23:43 Z

Source: Web Submission

Debrief Narrative: Found Aux Air Evaporator Drain Tube Broken in Flight Inspection Rack. Blower impeded by leaking water. Drain line repaired and water removed from blower motor compartment. Aircraft flown to verify corrective action.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N72

Tail Number: N72

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

While enroute from KBEA to KCRP level at 4000' the technician noticed a burning smell, within a few seconds smoke began to form in the back of the aircraft. The PIC directed everyone to don oxygen and run the appropriate emergency checklist. The crew declared an emergency with ATC and began a VFR descent into the closest suitable airfield – 1XA2 Chase Field Industrial (Pvt). The crew landed uneventfully within approximately 5 minutes of the emergency, cleared the runway, and evacuated the aircraft.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Source of smoke is undetermined at this time.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Exercised Captain Emergency Authority: Yes

Declared Emergency with ATC: Yes

Landed in Emergency Condition: Yes

Flight Status after Event:

Unplanned Emergency Landing: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 418

Overview:

Processing:

Status: Closed

ID: 418

Date/Time When Event Occurred: Mon, 28 Jun 2010 11:15 Z

Local Time When Event Occurred: 20:15

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 06 Jul 2010 20:42 Z

Submission Date/Time: Tue, 06 Jul 2010 20:42 Z

Source: Web Submission

Debrief Narrative: Performed N2 idle speed check and found RT engine to be .4% below lower minimum limit. Adjusted N2 idle speed IAW TI4109.2 Chapt 73. Also performed acceleration & decel check and power assurance checks with all parameters normal. Inspected VGV's and VGV feedback cable for freedom of movement. Inspected throttle controls and throttle rig to the main engine fuel control. All checks satisfactory. No other discrepancies noted. Resistance check of fan inlet temp sensor also good. Work completed by Dave Osborne, RU3A796U, RJSM, 6/28/10.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N86

Tail Number: N86

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

Enroute from Okinawa to Misawa AB, Japan, FL390 we started descent from fl390, reducing power to idle. Shortly thereafter, we noticed #2 engine parameters about half of #1 except ITT was much higher.

We also noticed then that #2 power lever movement had no effect and 2s parameters remained low. It appeared the #2 all but shutdown with minimal fuel flow but still producing it and electrical power.
Crew went thru several abnormal checklists regarding uncommanded deceleration or performance.
The apu started and the apu generator was subsequently used, activated as a precautionary measure.
After discussion, We elected to not shut down the engine because no parameters were exceeded and it was producing and electricity.
The environment was IMC, night time, in mountainous area.
At around 10000, #2 engine parameters appeared to return to normal, with a normal landing made. Approach/ landing made at the higher single engine landing speeds.

Phase of Flight:

Flight Phase at Start of Event: Descent

Cause

Narrative:

Maintenance determined that #2 idle was set too low.

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Declared Emergency with ATC: Yes

Operated in Degraded Conditions: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Narrative:

Better setting of engine idle speeds when maintenance is performed.

Deidentified Crewmembers Analyst SSE Report 416

Overview:

Processing:

Status: Closed

ID: 416

Date/Time When Event Occurred: Tue, 01 Jun 2010 18:46 Z

Local Time When Event Occurred: 14:46

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 01 Jun 2010 21:03 Z

Submission Date/Time: Tue, 01 Jun 2010 21:03 Z

Source: Web Submission

Debrief Narrative: Replaced left engine proximity switch. Adjusted IAW TI 4128.2 chapter 76.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N71

Tail Number: N71

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

Aircraft had maintenance work done on the Prop Governor causing a loss of am sortie. When aircraft was turned over to the crew for the afternoon sortie, crew executed normal takeoff and proceeded to VPZ. At approximately 1815z, while setting up for an ILS3, the

crew observed a master caution and associated "L Prop Pitch" light illumination. The light did not stay on but flickered several times along with the master caution. The light flickered through torque ranges from 30-90%. Crew elected to return the aircraft to Battle Creek and perform a precautionary landing. While enroute, the prop pitch light illuminated several more times but never came on steady through descent and landing. A landing, carrying power, was made at Battle Creek with no further event.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

UNKNOWN

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Operated in Degraded Conditions: Yes

Flight Status after Event:

Precautionary Landing: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 414

Overview:

Processing:

Status: Closed

ID: 414

Date/Time When Event Occurred: Wed, 26 May 2010 13:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 27 May 2010 12:43 Z

Submission Date/Time: Thu, 27 May 2010 12:43 Z

Source: Web Submission

Debrief Narrative: REMOVED AND REPLACED RIGHT MLG UPPER TRUNNION UP LOCK SWITCH S74. OPS CHECK GOOD IAW TI4107.2

CH 32-30-01 SWITCH P/N 1EN1-8, NSN NOTE:

NO OVERWEIGHT LANDING PERFORMED NO OVERWEIGHT LANDING INSP REQ.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N58

Tail Number: N58

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

On 1st ILS-3 low approach of first sortie at KEWB ILS 05, approx 1300Z. Broke off approach due to AFIS lockup. SIC raised landing gear handle. No gear action was observed visually or audibly. Gear indication remained down, 3 green, no red.

There were no checklist items to deal with this event. Elected to return gear handle to down position. Gear indication remained normal for down position.

Decided that there was no threat to safety of flight. Elected to return to KACY, VFR, to burn down fuel to landing weight and repair. Conducted a tower fly-by to verify gear was down. Proceeded with normal uneventful landing. Contacted FICO and MX on AIRINC to advise. Notified ATC along the way. No emergency was declared.

Phase of Flight:
Flight Phase at Start of Event: Go Around
Cause
Narrative:
Preliminary results from MX indicate problem may have been right main uplock switch.
Detection
How Event Detected:
Self Awareness/Scan: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Operated in Degraded Conditions: Yes
Flight Status after Event:
Diversion: Yes
Suggestions
Narrative:
None.

Deidentified Crewmembers Analyst SSE Report 413

Overview:
Processing:
Status: Closed
ID: 413
Date/Time When Event Occurred: Tue, 25 May 2010 18:00 Z
Local Time When Event Occurred: 10:00
Viewer Accessible: Yes
Initial Notification Date/Time: Tue, 25 May 2010 20:33 Z
Submission Date/Time: Tue, 25 May 2010 20:33 Z
Source: Web Submission
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N83
Tail Number: N83
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Narrative:
We were on an IFR flight in VMC conditions at 6000 MSL , Non-Radar, approx. six miles north of RWO NDB at Kodiak, AK. We received a TCAS TA with traffic 12 O'clock low and climbing rapidly. Began to query ATC and change heading, when we received an RA advising "Climb, Climb". We initiated climb, with traffic in sight , and received advisory "clear of conflict". We returned to assigned altitude and course and notified ATC.

ATC indicated that the traffic was VFR and not in radar contact.

Phase of Flight:
Flight Phase at Start of Event: Cruise
Cause
Narrative:
VFR aircraft and non radar environment.
Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes

Reaction
Flight Crew:
Contacted ATC: Yes
Override Automation: Yes
Took Evasive Action: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 411

Overview:
Processing:
Status: Closed
ID: 411
Date/Time When Event Occurred: Thu, 20 May 2010 20:48 Z
Local Time When Event Occurred: 16:48
Viewer Accessible: Yes
Initial Notification Date/Time: Fri, 21 May 2010 11:47 Z
Submission Date/Time: Fri, 21 May 2010 11:47 Z
Source: Web Submission
Debrief Narrative: Removed and replaced both L/H and R/H flap split switches and changed terminal connections to switches. Inspected flap control switch with no faults found and reinstalled access fixtures. Changed bushings on split switch control arm. Found old bushing to cause binding on switch.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N66
Tail Number: N66
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Narrative:
On 5/20/2010, at 2048Z, on approximately 2 NM final during a visual approach to Rwy 8 at KFTY, the pilot flying called for full flaps. I selected flaps, announced that the flaps were moving and then noted that the indicator stopped at an intermediate position, showing approximately 75%. I advised the pilot flying, and he stated he would continue the approach, using a Vref suitable for approach flaps (in this case 122 KIAS). I concurred and a normal landing was completed.
Phase of Flight:
Flight Phase at Start of Event: Approach
Cause
Narrative:
Unknown. Probably an aging aircraft issue.
Detection
How Event Detected:
Self Awareness/Scan: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Operated in Degraded Conditions: Yes
Flight Status after Event:
No Disruption: Yes
Suggestions
Narrative:
Buy new airplanes.

Deidentified Crewmembers Analyst SSE Report 410

Overview:

Processing:

Status: Closed

ID: 410

Date/Time When Event Occurred: Wed, 19 May 2010 18:03 Z

Local Time When Event Occurred: 14:03

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 20 May 2010 02:32 Z

Submission Date/Time: Thu, 20 May 2010 22:35 Z

Source: Web Submission

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N73

Tail Number: N73

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

While performing VFR flight inspection of LAL VTAC approximately 30 NM SW of KMCO at 3000 ft, received TCAS resolution alert. Orlando approach was very busy, and there were numerous VFR targets in the vicinity. Orlando had previously issued a traffic advisory to us approximately 5 minutes prior to the alert, but it is unknown if this was the same traffic that caused the TCAS alert. The TCAS did not announce any traffic or converging targets in front of us until a sudden, pop-up resolution alert (climb, climb) was received. At that time, the target was immediately in front of us and at our altitude. An immediate emergency climb/escape maneuver was initiated and maintained until a "clear of conflict" message was received. The conflict aircraft was never seen. It is possible that the conflict aircraft was performing aerobatics.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

It was a very nice VFR day, and there was significant light aircraft activity.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Took Evasive Action: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 402

Overview:

Processing:

Status: Closed

ID: 402

Date/Time When Event Occurred: Fri, 30 Apr 2010 15:40 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Sat, 01 May 2010 05:46 Z

Submission Date/Time: Sat, 01 May 2010 05:46 Z

Source: Web Submission

Debrief Narrative: -- Replaced IDG with servicable one from N88. Ops checked good on engine run. (Cannibilization)

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N87

Tail Number: N87

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

At FL 340 on J6 approximately 30NM west of ABQ, simultaneous disconnect of autopilot, illumination of yaw damp fail, both avionics cool air fail lights, 8/10 panel elec annunciator, and Master caution light. PF assumed manual control of aircraft. Subsequent cockpit scan revealed illumination of Gen #2 off light illuminated. Util buses were shed and main AC#2 auto transferred to Gen #1. Crew accomplished abnormal procedure checklist in attempt to recover failed Gen. Gen was not recovered by procedure. ATC notified of problem, informed that no assistance was required, and requested return to KOKC and descent to FL 290. Upon leveling at FL 290 and slowing to 270 KIAS, APU was started to have APU electrical power readily available in case of additional elec malfunction. Returned to KOKC to uneventful landing.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Gen #2 failed.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Contacted Operations: Yes

Flight Status after Event:

No Disruption: Yes

Precautionary Landing: Yes

Air Turnback: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 408

Overview:

Processing:

Status: Closed

ID: 408

Date/Time When Event Occurred: Wed, 28 Apr 2010 09:56 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 10 May 2010 17:03 Z

Submission Date/Time: Mon, 10 May 2010 17:03 Z

Source: Web Submission

Debrief Narrative: Event NOT recorded in aircraft logs, no maintenance action taken

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N59
Tail Number: N59
Aircraft Type: LR-60
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Narrative:
While conducting ILS-2 maneuvers for ILS 17 at KNFW, we encountered a small flock of starlings at our altitude. We were holding at 2100 feet MSL and turning outbound. At about 4nm north of the runway we struck the bird. It collided at the base of the windshield deice heat duct and bounced off. There was no damage to duct or sheet metal in the area.
Phase of Flight:
Flight Phase at Start of Event: Holding
Cause
Narrative:
This time of year the bird activity is very heavy
Detection
How Event Detected:
Flight Crew: Yes
Self Awareness/Scan: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Returned to Assigned Course/Heading: Yes
Returned to Assigned Speed: Yes
Flight Status after Event:
No Disruption: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 407

Overview:
Processing:
Status: Closed
ID: 407
Date/Time When Event Occurred: Thu, 22 Apr 2010 02:51 Z
Local Time When Event Occurred: 21:51
Viewer Accessible: Yes
Initial Notification Date/Time: Mon, 10 May 2010 14:08 Z
Submission Date/Time: Mon, 10 May 2010 14:08 Z
Source: Web Submission
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N71
Tail Number: N71
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Narrative:

The time of the event, as reported by ATC was 2151CDT, 0251Z. We blocked out of BTL at 0106, flew to O'Hare, and had already accomplished a periodic on MED ILS (Rwy 10). We had been sent around on the first low approach. O'Hare traffic was winding down. Weather had been good that day. They were not "backed up." O'Hare is always busy, they did not seem unusually so.

We were working 32R, they were departing to the east. I don't remember exactly the configuration of the airport at that time. I should not have been in their way. I had pushed for an early start to work on MED, Rwy 10. MED was carrying a closed window date of 7/28/2010, and had been removed from our schedule due to the city closing the runway at 1000 pm. In considering the rest of the O'Hare work, upcoming, it made very good sense to attempt the runway 10 work, at least the localizer, on this night. I had asked C90 and ORD ATCT if we could be worked in for a low approach to runway 10 prior to the closing of the runway. They agreed pending an easterly flow for the airport. Our itinerary carried a coordination note, "Coordinated by constance ctr randall : With ATC approval will attempt FC 2100L 4/22 if winds shift for ATC flow. City OPS to close rwy at 2200L". I told numerous individuals at C90 and ORD ATCT, in the coordination process, that all I needed early consideration for was the low approach to 10. I further told them that we would show up on approach frequency at about 9:00 PM CDT, and that we would be their control for the low approach on 10 when and if it became possible. I further told them that, at any time our early arrival became a problem, if they told us to do so, we would land at Midway, fuel, and return to work when things had quieted down. They called us in for 10, basically upon our arrival. We worked after the low approach on the basis of "what would you like next?", and our requests were forthcoming with virtually no delay. I am fairly certain that I stated on the frequency, after completing 10, that we could land at Midway and fuel, prior to starting 32R, if we were in the way. We were scheduled to start work at O'Hare at 0300Z, and I absolutely did not push them for an early start on 32R. I had pushed, only, for an early low approach on 10.

At approximately 2151 we received an RA. We were working 32R, in the Flight Inspection Holding Pattern at about 2200 feet. The RA was the result of a departing aircraft turning tightly off of 9R. I don't know if the controller or the pilot initiated the tight turn. We were VFR. We saw the aircraft's lights, recieved the RA, and responded to it, with a right climbing turn.

I have no way of knowing if the tower knew we were there. We had already made the low approach to 10, and been sent around once, as stated earlier. My point is, we had already talked to tower that night, so the facility should have known we were in the area. At the time of the RA, we were working with approach, VFR with a class B clearance.

I informed the approach controller, "We got an RA on that." He responded only with an acknowledgement and nothing further. I said nothing else.

The next day, I reported the event to AVN Chief Pilot Ed Lucke.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

We were working with Approach Control, the other aircraft was on Tower Frequency.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Contacted Company: Yes

Took Evasive Action: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 399

Overview:

Processing:

Status: Closed

ID: 399

Date/Time When Event Occurred: Tue, 20 Apr 2010 05:22 Z

Local Time When Event Occurred: 02:22

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 22 Apr 2010 15:43 Z

Submission Date/Time: Thu, 22 Apr 2010 15:55 Z

Source: Paper Submission

Debrief Narrative: The following defects and corrections were recorded under Work Order # 26159 as initial response to the deer strike:

1. LEFT INBOARD DEICE BOOT LOOSE---REPAIRED DEICE BOOT.
2. LT ENG - PROPELLER DOME DAMAGED BY DEER STRIKE---REPLACED PROPELLER DOME WITH NEW.
3. LEFT ENGINE OVERSPEED GOVERNOR DAMAGED BY DEER STRIKE---REPLACED LEFT ENGINE OVERSPEED GOVERNOR PER T.I 4128.2, M/M 61-20-00. ENGINE RUN OPS CK GD.
4. LEFT OUTBOARD FLAP DAMAGED BY DEER STRIKE---REPLACED LT. OUTBOARD FLAP I.A.W T.I. 4128.2, M/M 27-50-00. OP'S CK GD PER M/M 27-50-00.
5. LOWER RT ENGINE MOUNT PAD, LOCATED ON LT ENGINE, DAMAGED DUE TO DEER STRIKE ---REPLACED LOWER RT ENGINE MOUNT PAD ASSY IAW 71-20-00 AND CARD #1209.
6. LOWER LT ENGINE MOUNT PAD, LOCATED ON LT ENGINE, DAMAGED DUE TO DEER STRIKE. ---REPLACED LOWER LT ENGINE MOUNT PAD ASSY IAW 71-20-00 AND CARD #1209.
7. UPPER LT ENGINE MOUNT PAD DAMAGED DUE TO DEER STRIKE. LOCATED ON LT. ENGINE ---REPLACED UPPER LT ENGINE MONT ASSY IAW 71-20-00 AND CARD #1209.
8. UPPER RT ENGINE MOUNT PAD, LOCATED ON LT ENGINE, DAMAGED DUE TO DEER STRIKE. ---REPLACED UPPER RT ENGINE MOUNT PAD ASSY IAW 71-20-00 AND CARD #1209.
9. #1 eng OTBD exhaust stack bent from deer strike. ---Removed and replaced #1 eng OTBD exhaust stack IAW TI 4128.2.
10. LEFT ENGINE MOUNT ASSY. BENT BY DEER STRIKE. REMOVED AND REPLACED WITH NEW ASSY. REF TI4128.2 CH 71.20.00. INSPECTED BULKHEAD FOUND GOOD.
11. LEFT ENGINE ANTI-ICE VANE INOP IN MAIN. ---T/S LT. ANTI ICE VANE I.A.W. T.I 4128.2, M/M 30-20-00. CND LT. ANTI ICE VANE FAILURE. A/C OK FOR SERVICE.
12. LEFT COWLING BLACK ANTI GLARE PAINT MISSING FROM BOTTOM OF COWLING.---PAINTED BOTTOM OF COWLING WITH ANTI GLARE PAINT.
13. LEFT INBOARD DEICE BOOT LOOSE. ---REPAIRED DEICE BOOT.
14. LEFT LOWER AFT INBOARD INTERCOSTAL IS CRACKED---Removed and replaced cracked intercostal IAW TI4128.3.
15. LEFT ENGINE GENERATOR COOLING DUCT IS CRACKED. ---Removed and replaced Left eng gen. cooling duct IAW TI4128.3.
16. Found prop sync pickup damaged at tip. ---Removed and replaced prop sync pickup on #1 eng IAW TI4128.2. Needs ops check after eng installation. -- ops checked good IAW card 1502 step 10.
17. LEFT LOWER FWD COWLING DAMAGED DURING DEER STRIKE. ---REMOVED AND REPLACED COWLING. -- REMOVED COWLING S# ATL-10
- 18 REMOVED AND REPLACED LEFT ENGINE IAW CARD 1601L. -- REPLACED LT. ENGINE I.A.W W.O # 26159, CARD #1208 AND CARD # 1209---LT ENG AND PROPELLER CHANGE, WITH ADDITIONAL DAMAGE INSPECTIONS, IN PROGRESS. -- Rigged Left Engine and Propeller controls IAW Cards 1209, 1207 and TI 4128.2, Procedural Operational checks found good.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N77

Tail Number: N77

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

NOTE: This SSE was received via fax from the FICO and input by the Analyst

Leonard Burger (PIC), Jerry Kuzia (SIC), and Edward Magaw (MS) completed a flight inspection mission at Atlanta Hartsfield Intl. Airport and landed RWY 28 at Fulton County Airport. Clearance was requested and granted to exit the runway at taxiway Alpha to the FAA ramp. The aircraft was slowed considerably during the rollout because of the known potential for deer and coyotes on the airport property. At approximately midfield an unknown object struck the aircraft. It was also unknown where on the aircraft the object struck. At the point of impact I caught a vague glimpse of something in my peripheral vision out the left pilots window which I suspected may have been a deer. It appeared forward of the wing and seemed to be moving outward from the engine nacelle. After engine shutdown on the FAA ramp, inspection revealed all four propeller blades of the left engine were bent. Hair and blood were observed particularly on the left wing leading edge, the windscreen, and the underside of the left outer flap. There was also a dent on the underside of the left outer flap. Airport Fire Department personnel removed the animal remains from the runway. Tower personnel confirmed it was a deer.

Phase of Flight:

Flight Phase at Start of Event: Rollout Landing

Cause

Narrative:

Natural occurrence.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

Taxi: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 397

Overview:

Processing:

Status: Closed

ID: 397

Date/Time When Event Occurred: Tue, 13 Apr 2010 18:00 Z

Local Time When Event Occurred: 11:00

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 14 Apr 2010 16:25 Z

Submission Date/Time: Wed, 14 Apr 2010 16:25 Z

Source: Web Submission

Debrief Narrative: Deferred with DMI Number: 1025 Installed new downlock switch IAW Ti 4128.2 chapter 32-60-00. Ops check good.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N84

Tail Number: N84

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

In the course of conducting an ILS periodic/monitors inspection at KRAL, it was noted during configuring for an ILS-3 low approach that the left landing gear had a delayed green light indication of about four-five seconds after the other two gears had indicated down and locked. The light bulb was checked and indicated normally. During two subsequent gear cycles we saw the same thing. At the third cycle, the delay increased to over ten seconds after the other two gears indicated down. No unusual yawing or sounds were

noted. It was decided to leave the landing gear down after the last low approach. All three gears indicated down and locked at that point. We completed one additional low approach in the gear down configuration to complete the check and returned the aircraft to KLGB where a normal landing was made. ATC was not advised nor was an emergency declared as we had a normal down and locked indication. The abnormal operation of the gear was written up in the log book and the aircraft turned over to maintenance at KLGB.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Unknown at this point.

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Operated in Degraded Conditions: Yes

Flight Status after Event:

Diversion: Yes

Suggestions

Narrative:

Not applicable.

Deidentified Crewmembers Analyst SSE Report 396

Overview:

Processing:

Status: Closed

ID: 396

Date/Time When Event Occurred: Tue, 13 Apr 2010 06:50 Z

Local Time When Event Occurred: 02:50

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 13 Apr 2010 08:18 Z

Submission Date/Time: Tue, 13 Apr 2010 08:18 Z

Source: Web Submission

Debrief Narrative: Small hole in right engine nacelle above hot lip. Found on post flight, suspect bird strike. -- INSPECTED AREA FOR SUSPECTED BIRD STRIKE. Found no evidence of a bird strike. Repaired Small Hole. All work repaired IAW TI 4128.3 Chapter 20-10-03

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N80

Tail Number: N80

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

Mission Specialist indicated he heard a "thump" during ILS-2 maneuvers at ORD. Flight did not notice any abnormal conditions. Noticed small hole in right nacelle just above intake lip.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Possible bird strike.

Detection

How Event Detected:
Cabin Crew: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Status after Event:
No Disruption: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 395

Overview:
Processing:
Status: Closed
ID: 395
Date/Time When Event Occurred: Mon, 12 Apr 2010 15:45 Z
Local Time When Event Occurred: 11:45
Viewer Accessible: Yes
Initial Notification Date/Time: Mon, 12 Apr 2010 18:20 Z
Submission Date/Time: Mon, 12 Apr 2010 18:20 Z
Source: Web Submission
Debrief Narrative: Strong burnt odor experienced during power climb out about the same time as flaps were retracted-- Removed and replaced fwd and aft evaporator filters and ran engines. Could not duplicate on ground at all environmental settings

Event: 1
Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N78

Tail Number: N78

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

After completion of PAR fifty (50) foot recorded run, power was applied and a climb to assigned heading [360 degrees] and altitude [3000MSL] was initiated. Landing Gear was retracted with positive rate of climb and approximately 10 degrees nose up attitude. Upon reaching V2 plus 14KTS flaps were retracted to the full up position.

As flaps moved to the full up position, cockpit crew and then rear cabin crew [Mission Specialist and Mission Specialist in training] noticed a strong 'burnt toast' smell throughout the aircraft. Aircraft diverted to homebase [approximately 7NM from work location] and landed without further incident.

Aircraft given to AVN300 (ATL) Maintenance who conducted ground runs and noticed the same smell. Status unknown at this time.

Phase of Flight:

Flight Phase at Start of Event: Climb

Cause

Narrative:

Unknown.

Detection

How Event Detected:

Cabin Crew: Yes

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:
Contacted ATC: Yes
Flight Status after Event:
Precautionary Landing: Yes
Diversion: Yes
Flight Cancellation: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 394

Overview:
Processing:
Status: Closed
ID: 394
Date/Time When Event Occurred: Fri, 09 Apr 2010 14:35 Z
Local Time When Event Occurred: 09:35
Viewer Accessible: Yes
Initial Notification Date/Time: Sat, 10 Apr 2010 22:35 Z
Submission Date/Time: Sat, 10 Apr 2010 22:35 Z
Source: Web Submission

Debrief Narrative: Acft was ground checked in hangar with GPU. All available internal and external electrical, avionic, mission equip, environmental systems were on and cycled individually and/or in groups. Acft was ground and checked using some system conditions and settings at various power settings and was pressurized and temp cycled from full A/C to full heat. Eng cowlings removed and engines inspected. Ambient air ducts good. Tech floor head pad inspected and turned on. Center floor panels, avionics bays inspected and bays inspected internally and externally. Glare shield loosened and shook with W/S heat on, cycled hi to low. Total time estimated in hangar with power on 2+ hrs. Ground run time almost 1 hr. Me and Mr. Mark Allen both agree that no odor or smell of electrical problems were present at any Time during these checks. We have not noticed any discrepancies or system faults.

Event: 1
Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N73

Tail Number: N73

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

On 04/09/2010, at 0935 est. In-flight to KRUQ (Salisbury NC) to perform flight inspection. At approximately twenty miles from station, at 5000 feet, the Co-pilot (SIC) noted an electrical burning smell. The Mission Specialist and Pilot flying (PIC) confirmed the odor. SIC initiated the appropriate checklist, ATC notified. Precautionary landing made at KCLT (Charlotte NC). The electrical smell dissipated prior to landing. Local maintenance duplicated the smell on the ground, but was unable to determine the source.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Source of the electrical burning smell unknown.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Flight Status after Event:
Precautionary Landing: Yes
Suggestions
Narrative:
N/A

Deidentified Crewmembers Analyst SSE Report 392

Overview:
Processing:
Status: Closed
ID: 392
Date/Time When Event Occurred: Fri, 26 Mar 2010 04:45 Z
Local Time When Event Occurred: 20:45
Viewer Accessible: Yes
Initial Notification Date/Time: Fri, 26 Mar 2010 19:36 Z
Submission Date/Time: Fri, 26 Mar 2010 19:36 Z
Source: Web Submission
Debrief Narrative: Windshield removed and replaced.

Maintenance Action Directive 10-05 Inspection of Beech Fleet windshields issued.
Maintenance Action Directive 10-06 Installation inspections and replacement of -15 and -16 Beech Fleet windshields issued.

Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N83
Tail Number: N83
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Flying
Narrative:
Approximately 30 minutes from departure at 16,000 feet, there was a loud gunshot like noise. The front right windscreen shattered. We requested return to ANC (nearest suitable airport) from ATC, began a descent to 9500' and performed the abnormal shattered windshield check list.
Phase of Flight:
Flight Phase at Start of Event: Cruise
Cause
Narrative:
Thermal or mechanical stress.
Detection
How Event Detected:
Self Awareness/Scan: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Contacted ATC: Yes
Override Automation: Yes
Flight Status after Event:
Air Turnback: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 391

Overview:

Processing:

Status: Closed

ID: 391

Date/Time When Event Occurred: Mon, 22 Mar 2010 18:45 Z

Local Time When Event Occurred: 13:45

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 23 Mar 2010 13:27 Z

Submission Date/Time: Tue, 23 Mar 2010 13:27 Z

Source: Web Submission

Debrief Narrative: Found upper AFT door switch out of adjustment. Adjusted Aft Door switch per TI 4128.2 chapter 52. Pressurized aircraft to 6 psi. Door warning system checked satisfactory.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N72

Tail Number: N72

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

WHILE CLIMBING TO ENROUTE CRUISING ALTITUDE OF FL190 SOUTH OF OKC "CABIN DOOR " ANNUNCIATOR ILLUMINATED AT APPROX. 18700'. PF EXECUTED EMERGENCY DESCENT AND "CABIN DOOR UNLOCK" EMERGENCY PROCEDURES. PNF DECLARED EMERGENCY WITH FTW ARTCC AND FOLLOWED THROUGH WITH EMERGENCY CHECKLISTS. AIRCRAFT RETURNED TO OKC APPROX. 35NM NORTH. AT 9000 MSL "CABIN DOOR" ANNUNCIATOR EXTINGUISHED. AIRCRAFT WAS LANDED UNEVENTFULLY AT OKC. INSPECTION OF DOOR AFTER LANDING INDICATED IT WAS SECURELY LATCHED.

Phase of Flight:

Flight Phase at Start of Event: Climb

Cause

Narrative:

UNKNOWN AT THIS TIME

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Exercised Captain Emergency Authority: Yes

Declared Emergency with ATC: Yes

Contacted Operations: Yes

Executed Emergency Descent: Yes

Flight Status after Event:

Unplanned Emergency Landing: Yes

Suggestions

Narrative:

AIRCRAFT WAS JUST OUT OF A MAINTENANCE CHECK, IF THE CABIN DOOR MICRO SWITCH IS WORKED ON DURING CHECK THEN PERFORM PRESSURIZATION CHECK ON AIRCRAFT BEFORE RELEASING TO FLIGHT LINE.

Deidentified Crewmembers Analyst SSE Report 390

Overview:

Processing:

Status: Closed

ID: 390

Date/Time When Event Occurred: Tue, 16 Mar 2010 21:05 Z

Local Time When Event Occurred: 04:12

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 22 Mar 2010 16:06 Z

Submission Date/Time: Mon, 22 Mar 2010 16:06 Z

Source: Web Submission

Debrief Narrative: 03/19/10 Performed the following maintenance actions: applied external power to aircraft and operated the Aux A/C, Fwd and Aft blowers, AFIA Power, Avionics power and inverters. Ran systems for 1 hour with no abnormal indications or burning smell. Ran engines with generator power with Aux A/C, fwd and aft Blowers, A/C, AFIS power, avionics power, and inverters for 45 minutes. No abnormal indications or burning smell noted,

03/20/10 Removed left and right inboard leading edges, left access panels, center cabin floorboards. Inspected all accessible wiring, breakers, contactors, relays and current limiters and circuit breakers for loose chaffing or aching. No discrepancies found.

Inspected all accessible systems during this time and found no abnormalities or evidence of burning or smoke. All indications on amp meter and volt meter were normal. No negative deflections on amp meter noted, powered down aircraft and installed all previously removed covers and panels and restored aircraft to normal. Aircraft flew 1.1 hours back to OKC on 03/22/2010 with no burning smell. Aircraft was again operated for 2 hours with no problems.

03/22/2010 Nightshift avionics technicians removed and inspected and then reinstalled the following components: Both EFIS tubes, AFIS CDU, Pilots KAV-485, TCAS control, Trimble CDU, Tech's IC and audio monitor panels, lowered and inspected overhead lighting control panel, inspected the techs Molex connector for the floor heat, found no evidence of overheating of components or smoke smell. Aircraft returned to service, no defects found (Transferred DDL #50 writ-up to logbook page 136115, BLK 1 & 2).

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N77

Tail Number: N77

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

Smoke smelled in cockpit. Strong smell of smoke outside of aircraft. Nothing found. Next AM, Batt volts showed 0 voltage. Busses would not come on line initially. Contacted maintenance, mechanic came to KHOT and inspected aircraft. Nothing found. On Friday morning, in flight, BATT Bus showed 60+ amp discharge, center and tripple fed bus off line, then on line, batt 60+ amp discharge, AFIS and IRU interrupted. Landed w/o event. Maintenance came to inspect. Could not find problem. SFP to take aircraft back to KOKC

Phase of Flight:

Flight Phase at Start of Event: Descent

Cause

Narrative:

UNKNOWN

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Landed in Emergency Condition: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 388

Overview:

Processing:

Status: Closed

ID: 388

Date/Time When Event Occurred: Fri, 05 Mar 2010 20:30 Z

Local Time When Event Occurred: 15:30

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 09 Mar 2010 19:52 Z

Submission Date/Time: Tue, 09 Mar 2010 19:52 Z

Source: Web Submission

Debrief Narrative: Re-seated cap. Ops checked good IAW 4128.2 Chapter 28.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N80

Tail Number: N80

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Narrative:

At approximately 3:20pm, crew departed Flint Michigan after performing flight check of the Flint ASR. We had been airborne about 40 minutes and had picked up our IFR to Battle Creek. Aircraft was climbed to 8000 and accelerated to 230kts. At that time, the Mission Specialist noted what appeared to be a contrail coming off of the left wing. He made a comment to the crew about it. I, the PIC, advised him that that was not a contrail, it was fuel being sucked out of the left wing. At the time the event was noticed, we were 20 miles from Battle Creek, 18 miles from Jackson and 20 some miles from Lansing. I elected to proceed to Battle Creek and slow the aircraft down to lessen the vacuum over the wing. Upon arrival at Battle Creek, there were two Western Michigan University aircraft in the pattern in front of us and I advised tower of the fuel leak and asked to cut in front of the other two aircraft. I advised no rolling of fire vehicles was being asked for at this time. Precautionary landing was made. Landing was uneventful, aircraft was taxied to parking and shutdown. It was found that the left wing fuel cap was flat with the wing but upon opening it, it was noted that the lanyard appeared to have been caught in the threads when the cap was closed.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

The Flint Michigan FBO personnel fueled the aircraft and put the fuel cap on incorrectly. The SIC and the PIC performed a walk-around and did not notice the cap out of place. The cap was not completely secured and allowed fuel to be siphoned out of the wing tank at high speed.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Flight Status after Event:

Precautionary Landing: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 386

Overview:

Other Employees:
Employee Duty: Pilot Monitoring/Pilot Not Flying
Employee Number: VN003
First Name: Paul
Middle Initial: R
Last Name: Armstrong
Other Employees:
Employee Duty: Pilot Flying
Employee Number: VN284
First Name: Todd
Last Name: Haifly
Other Employees:
Employee Duty: Mission Specialist
Employee Number: VN157
First Name: Roy
Last Name: Spainhower
Processing:
Status: Closed
ID: 386
Date/Time When Event Occurred: Fri, 05 Mar 2010 06:06 Z
Local Time When Event Occurred: 02:06
Viewer Accessible: Yes
Initial Notification Date/Time: Mon, 08 Mar 2010 17:39 Z
Submission Date/Time: Mon, 08 Mar 2010 17:40 Z
End of Trip Date/Time: Fri, 05 Mar 2010 06:06 Z
Source: Web Submission
Debrief Narrative: Maintenance activity inspected electrical components under floor fwd. of spar and aft of pedestal. In addition inspected IRU, EFIS cooling fans and avionics rack cooling fans. All systems checked good on ground power unit and with engines running. No further occurrences of fumes found.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N67
Tail Number: N67
Aircraft Type: BE-300
Flight Crew Employee Information:
Duty Off Time: Fri, 05 Mar 2010 07:45 Z
Duty On Time: Fri, 05 Mar 2010 02:00 Z
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Flight Information:
Time of Day: Night
Scheduled Arrival Airport, Runway and Gate: KUGN
Landing Airport, Runway and Gate: KUGN
Geographic Location:
Airport: KUGN
Narrative:
After the AFIS system had given erroneous results we landed at UGN to power down and reset the system. After power up, electrical fumes were present in the flight deck. We shut down the electrics and engines and evacuated the aircraft.
Passenger Misconduct:
Dangerous Goods: Smoke/Fumes
Phase of Flight:
Flight Phase at Start of Event: Parked
Weather:
Meteorological Conditions: VMC

Cause
Narrative:
Suspect an electrical component overheated.
Detection
When Event Detected:
PostFlight: Yes
Reaction
Flight Crew:
Engine Shutdown: Yes
Flight Status after Event:
Evacuation: Yes
Flight Cancellation: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 385

Overview:
Other Employees:
Employee Duty: Pilot Monitoring/Pilot Not Flying
Employee Number: VN003
First Name: Paul
Middle Initial: R
Last Name: Armstrong
Other Employees:
Employee Duty: Pilot Flying
Employee Number: VN284
First Name: Todd
Last Name: Haifley
Other Employees:
Employee Duty: Mission Specialist
Employee Number: VN157
First Name: Roy
Last Name: Spainhower
Processing:
Status: Closed
ID: 385
Date/Time When Event Occurred: Fri, 05 Mar 2010 05:05 Z
Local Time When Event Occurred: 23:05
Viewer Accessible: Yes
Initial Notification Date/Time: Mon, 08 Mar 2010 17:15 Z
Submission Date/Time: Mon, 08 Mar 2010 17:15 Z
Source: Web Submission
Debrief Narrative: Crew reported laser incident to ATC.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
ATC Information:
Name of ATC Facility: ORD TRACON
Aircraft Configuration:
Nickname: N67
Tail Number: N67
Aircraft Type: BE-300
Speed IAS (Knots): 180
Aircraft Events:
Laser Beam Exposure: Yes

Flight Crew Employee Information:

Duty Off Time: Fri, 05 Mar 2010 07:45 Z

Duty On Time: Fri, 05 Mar 2010 02:00 Z

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Flight Information:

Flight Number: FLC67

Time of Day: Night

Geographic Location:

Airport: ORD/KORD - 09R/27L

Narrative:

Possible lazer encounter, Aircraft Location approx N41-58-55.9, W87-40-35.0, leftside of aircraft heading 312 on 8.5 mile left base to RWY 27L ORD. Altitude 2250 feet MSL (1500 feet AGL.) Green bright light reported to ORD TRACON. Time 0505Z. No injuries to crew.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Unauthorized Lazer activity.

Detection

Reaction

Action Taken:

Insufficient Time to Take Action: Yes

Flight Crew:

Contacted ATC: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 387

Overview:

Processing:

Status: Closed

ID: 387

Date/Time When Event Occurred: Thu, 04 Mar 2010 14:08 Z

Local Time When Event Occurred: 08:08

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 09 Mar 2010 13:33 Z

Submission Date/Time: Tue, 09 Mar 2010 13:33 Z

Source: Web Submission

Debrief Narrative: SSE forwarded to Jim Powell, Manager of Air Traffic Aviation Safety Action Program (AT ASAP) for inclusion in AT ASAP.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N79

Tail Number: N79

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

During start up/taxi (at KPNS) found one controller working Clearance Delivery, Ground Control, and Tower.

Controller missed calls due to this configuration. Two regional jets were ready for departure and a Cessna was taxiing. We were trying to get a taxi clearance. Not sure if any aircraft were in the pattern.

I asked the controller for the supervisors phone number (wanted to discuss this configuration). The controller gave me the number and stated over all three frequencies "don't call me now I'm the only person here." Controller was professional but very busy working all three frequencies.

Phase of Flight:

Flight Phase at Start of Event: Taxi-Out

Cause

Narrative:

Unknown. Suspect controller staffing issues.

Detection

How Event Detected:

ATC: Yes

When Event Detected:

Taxi: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Narrative:

I feel this configuration is very unsafe. A recent air carrier fatal accident comes to mind, when there was only one controller in the tower at the time of the accident (KLEX).

KPNS can get busy at this time of morning (air carrier, GA, and military transient traffic).

My suggestion would be to review tower procedures that allows this configuration to exist.

It is my opinion that if this configuration is allowed to continue an incident/accident is likely to occur in the future.

Deidentified Crewmembers Analyst SSE Report 384

Overview:

Processing:

Status: Closed

ID: 384

Date/Time When Event Occurred: Mon, 01 Mar 2010 21:00 Z

Local Time When Event Occurred: 11:00

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 02 Mar 2010 23:47 Z

Submission Date/Time: Tue, 02 Mar 2010 23:47 Z

Source: Web Submission

Debrief Narrative: Replaced Pilots front windscreen IAW TI 4109.2 Chpt. 56-10-11. Windshield heat and pressurization and leak check satisfactory.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N87

Tail Number: N87

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Narrative:

After approx 1.0 hours of flying in the climbout to our next work we noticed the windshield splitting from a small scratch. We leveled off 17,000 feet, ran the checklist and got clearance to return to Anchorage.

Phase of Flight:

Flight Phase at Start of Event: Climb

Cause

Narrative:

Scratch developed into a crack.

Detection

How Event Detected:

Cabin Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Flight Status after Event:

Precautionary Landing: Yes

Air Turnback: Yes

Diversion: Yes

Suggestions

Narrative:

Replace Challenger windshields with glass. Place more emphasis on front windshield scratches.

Deidentified Crewmembers Analyst SSE Report 383

Overview:

Processing:

Status: Closed

ID: 383

Date/Time When Event Occurred: Mon, 22 Feb 2010 22:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 23 Feb 2010 16:57 Z

Submission Date/Time: Tue, 23 Feb 2010 17:07 Z

Source: Paper Submission

Debrief Narrative: Correction

-- Removed and replaced co-pilots windscreen. Cure ck and heat ck good IAW TI 4128.2, chap 56-10-00 and beech acft corp drawing 101-5043. Windshield P/N PA101-384025-24, S/N 132, Install kit P/N 101-5041-3, S/N 29836.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N81

Tail Number: N81

Aircraft Type: BE-300

Narrative:

At approximately 2000Z, a lot of noise, like a pistol shot was heard in the aircraft. The front right windscreen shattered. We donned O2 masks, immediately initiated a max descent from FL 230 to 5000 ft. The shattered windscreen and emergency descent checks were completed with the exception of the cabin dump.

IMC at altitude with light to moderate icing. Layers to 3,000 ft. VFR at field (KOMA).

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Thermal or mechanical stress.

Detection

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Executed Emergency Descent: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 381

Overview:

Processing:

Status: Closed

ID: 381

Date/Time When Event Occurred: Fri, 05 Feb 2010 17:29 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 08 Feb 2010 18:34 Z

Submission Date/Time: Mon, 08 Feb 2010 18:35 Z

Source: Web Submission

Debrief Narrative: Correction -- Replaced pilot windshield IAW TI 4128.2 56-10-00 and per window installation inst. Ops checked window heat good.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N72

Tail Number: N72

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

After 45 minutes from departing Jefferson City Mo. enroute to Oklahoma City, OK at FL260, there was a loud sound like a gun shoot and the pilot side windshield was shattered along with shrouds of glass falling out. I informed Kansas City Center what the situation was and requested an immediate descent to the closes VFR airport with 6000 feet of runway. Abnormal shattered windshield check list was performed and PNF landed the aircraft.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Don't know

Detection

How Event Detected:

Self Awareness/Scan: Yes

Reaction

Flight Crew:

Declared Emergency with ATC: Yes

Contacted ATC: Yes

Flight Status after Event:

Planned Emergency Landing: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 376

Overview:

Processing:

Status: Closed

ID: 376

Date/Time When Event Occurred: Wed, 03 Feb 2010 15:15 Z

Local Time When Event Occurred: 10:15

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 03 Feb 2010 15:57 Z

Submission Date/Time: Wed, 03 Feb 2010 15:57 Z

Source: Web Submission

Debrief Narrative: REPLACED RT AUX FUEL BLADDER, Resealed wing to fuselage area

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N73

Tail Number: N73

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Narrative:

After engine start (both engines) all crewmembers (3) smelled strong jet fuel odor in cockpit and cabin. Continued after start checklist awaiting fuel odor to dissipate. After completing after start checklist odor persisted. Informed MX via radio and shut down both engines.

MX pulled floor boards and found fuel under observers seat in belly of fuselage.

MX currently working problem at this writing.

Phase of Flight:

Flight Phase at Start of Event: Predeparture/Preflight

Cause

Narrative:

Fuel leak.

Detection

How Event Detected:

Other Aircraft/Pilot: Yes

When Event Detected:

PreFlight: Yes

Reaction

Flight Crew:

Contacted Maintenance: Yes

Flight Status after Event:

Flight Delay: Yes

Suggestions

Narrative:

MX issue. MX should submit suggestion.

Deidentified Crewmembers Analyst SSE Report 374

Overview:

Processing:

Status: Closed

ID: 374

Date/Time When Event Occurred: Mon, 01 Feb 2010 15:24 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 01 Feb 2010 15:41 Z

Submission Date/Time: Mon, 01 Feb 2010 15:42 Z

Source: Web Submission

Debrief Narrative: REMOVED AND REPLACED AUTOPILOT COMPUTER AND AILERON SERVO MOTOR. OP CHECKS OK. REF TI4128.2, CHAPTER 22.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N69

Tail Number: N69

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

During climb out after 1000 MSL pilot flying (VN111) went to engaged autopilot. HDG & ALT SEL selected for phase of flight. A/C made an immediate 30° roll left & 30° roll right. Followed by autopilot disconnecting and illumination of RED Warning Lights and tone of A/P disconnect. Reset A/P & Trim switch and after successful self test re-attempt to engage A/P only to have same results. A/C was still within approx 5NM of ACY at @ 3000Ft. VFR on IFR flight plan. Notified ATC for return to ACY. Ground A/P self test prior to flight was satisfactory. Company abnormal checklist consulted for appropriate actions.

Phase of Flight:

Flight Phase at Start of Event: Initial Climb

Cause

Narrative:

Trouble shooting on ground with ACY maintenance found A/P servo had failed.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Flight Status after Event:

Air Turnback: Yes

Flight Cancellation: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 375

Overview:

Processing:

Status: Closed

ID: 375

Date/Time When Event Occurred: Mon, 25 Jan 2010 08:18 Z

Local Time When Event Occurred: 10:18

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 01 Feb 2010 16:51 Z

Submission Date/Time: Mon, 01 Feb 2010 16:51 Z

Source: Web Submission

Debrief Narrative: Correction

-- Performed Automatic press control sys test, system failed step (11). Reseated cannon plug on pressure controller, re-preformed auto press controller sys test, system checked good IAW TI4109.2 Chapt 21-30-00

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N86

Tail Number: N86

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

After engine shutdown, cabin differential 2.0 to 1.0. You could hear air trying to escape the crew entry door. Auto controller iwas in auto mode. Aircraft obviously remained pressurized after landing. Had the door been opened---someone could have been seriously injured/killed.

Phase of Flight:

Flight Phase at Start of Event: Arrival Shutdown

Cause

Narrative:

We completed auto press controller ground checks with MX. System failed step (11). Cannon plugs on press controller reset. completed additional auto pressure controller test- ops check good. (Mission delayed 2 to 2.5 hours)

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

PostFlight: Yes

Reaction

Flight Crew:

Contacted Maintenance: Yes

Flight Status after Event:

Flight Delay: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 373

Overview:

Processing:

Status: Closed

ID: 373

Date/Time When Event Occurred: Tue, 12 Jan 2010 14:30 Z

Local Time When Event Occurred: 09:30

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 19 Jan 2010 20:09 Z

Submission Date/Time: Tue, 19 Jan 2010 20:10 Z

Source: Web Submission

Debrief Narrative: Following the discrepancy, maintenance personnel found the LH engine inboard exhaust flex tube broken. Faulty component was removed and replaced with a new component in accordance with TI4128.2 chapter 32.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N74

Tail Number: N74

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Narrative:

After first start of the week, we noticed an exhaust odor in the cabin similar to the smell we sometimes get when the aircraft is started with the tail into the wind. We also noticed air flowing around the metal lip that was installed on the emergency exits. It was thought that either the tail facing into the wind, the air around the exits or the compressor wash that maint said had been done was the source of the smell. Once the aircraft pressurized the smell dissipated. We noticed the odor on each start but the smell would dissipate. On the final start we decided to leave the bleeds off completely and check them individually after the start. We thought there might be a smell when the left bleed was turned on but were unsure. On touch down we immediately got the odor during roll out. We wrote the aircraft up and maint found a broken flex line to the lip heat on the left engine. I suggest that CO detectors be placed in the aircraft.

Phase of Flight:

Flight Phase at Start of Event: Engine Start/Pushback

Cause

Narrative:

see above

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

Taxi: Yes

Reaction

Suggestions

Narrative:

see above

Deidentified Crewmembers Analyst SSE Report 370

Overview:

Processing:

Status: Closed

ID: 370

Date/Time When Event Occurred: Thu, 17 Dec 2009 15:15 Z

Local Time When Event Occurred: 09:15

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 17 Dec 2009 18:32 Z

Submission Date/Time: Thu, 17 Dec 2009 18:32 Z

Source: Web Submission

Debrief Narrative: REMOVED AND REPLACED THE LEFT WINDSHIELD IAW T.I. 4109.2 CHAP 56-10-11 AND CHAPTERS 30 AND 21. LEAK AND OP CK GOOD

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N86

Tail Number: N86

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

In cruise flight at FL350 enroute from Oklahoma City to Hot Springs Virginia, the left pilot windshield cracked the entire vertical length of the window. Pressurization was checked and Abnormal Checklist for Windshield Outer Face Ply Failure was accomplished.

ATC and FICO were advised and turn around conducted. In order to obtain landing weight aircraft was descended and reconfigured. Uneventful landing was conducted at Oklahoma City.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Not uncommon occurrence in Challenger aircraft.

Detection

How Event Detected:

Flight Crew: Yes

Other Aircraft/Pilot: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Changed Configuration-Flaps/Trim: Yes

Contacted ATC: Yes

Contacted Company: Yes

Flight Status after Event:

Air Turnback: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 372

Overview:

Processing:

Status: Closed

ID: 372

Date/Time When Event Occurred: Thu, 17 Dec 2009 13:47 Z

Local Time When Event Occurred: 08:47

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 18 Dec 2009 18:45 Z

Submission Date/Time: Fri, 18 Dec 2009 18:45 Z

Source: Web Submission

Debrief Narrative: Maintenance input: Initially deferred by FICO, temp repair installed at PQI, with the following logbook entry:

"Deferred with DMI Number: 56 Inspected tail forward cone and found no structural damage. Made temporary airworthy repair of small hole in fairing with speed tape. Work performed by Peter J Perry at Telford Aviation crs # J2SR196J."

Once the aircraft returned to home station the bullet fairing was replaced with the following logbook entry: "REMOVED AND REPLACED HORIZONTAL STAB NOSE CONE IAW TI4128.2. SEALED AS REQUIRED."

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N76

Tail Number: N76

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

Evidence of bird strike to upper elevator tail surface detected during pre-flight. Previous landing occurred at night and no abnormalities discovered post flight due to darkness and location of A/C on ramp. Bird impact appeared to initially hit the torpedo tip of the elevator shroud and right elevator de-ice boot leading edge toward the wing root.

Birds were noticed near runway edge and over runway on T/O from PQI just prior to V2 @119kts but not at departure end. This is probably when strike occurred but crew did not detect anything abnormal that would have alerted them. T/O and flight continued normally.

Flight delayed until inspection by a mechanic could be completed.

Phase of Flight:

Flight Phase at Start of Event: Predeparture/Preflight

Cause

Narrative:

Unfortunate contact of bird to A/C.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

PreFlight: Yes

Reaction

Flight Status after Event:

Flight Delay: Yes

Suggestions

Narrative:

Birds are a constant hazard to all A/C. While every effort may be made, avoidance with birds may not always be possible.

Deidentified Crewmembers Analyst SSE Report 368

Overview:

Processing:

Status: Closed

ID: 368

Date/Time When Event Occurred: Fri, 11 Dec 2009 19:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 14 Dec 2009 16:58 Z

Submission Date/Time: Mon, 14 Dec 2009 16:59 Z

Source: Web Submission

Debrief Narrative: Maintenance determined the subject latch was slightly out of rig, and it was adjusted and corrected.

Maintenance will also add expanded information on the correct operation of these latches to the Be-300 maintenance manual.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N67

Tail Number: N67

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

While conducting an ILS-1 maneuver, SIC in right seat observed that the #2 inboard forward portion of engine cowl was loose. Immediately notified ATC, disconnected autopilot and then executed a full stop landing on RWY 25R at KMKE.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Unknown, possibly inflight vibration. Engine cowl was observed to be normal during preflight. Total flight time in this sortie was approx. 1.5 hours prior to this event.

Detection

How Event Detected:

Flight Crew: Yes

Other Aircraft/Pilot: Yes

Self Awareness/Scan: Yes

When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Landed in Emergency Condition: Yes
Contacted ATC: Yes
Contacted Company: Yes
Contacted Maintenance: Yes
Contacted Operations: Yes
Operated in Degraded Conditions: Yes
Overrode Automation: Yes
Flight Status after Event:
Precautionary Landing: Yes
Diversion-Other Alternate: Yes
Flight Delay: Yes
Suggestions
Narrative:
Inspection of entire fleet to check the wear on similar latches / cowlings.

Deidentified Crewmembers Analyst SSE Report 369

Overview:
Processing:
Status: Closed
ID: 369
Date/Time When Event Occurred: Thu, 10 Dec 2009 14:00 Z
Local Time When Event Occurred: 09:00
Viewer Accessible: Yes
Initial Notification Date/Time: Tue, 15 Dec 2009 13:36 Z
Submission Date/Time: Tue, 15 Dec 2009 13:36 Z
Source: Web Submission
Regulation: Found small leak at bleed air coupling Dist Duct. Replaced seals. Removed and replaced R/H FWD loop detector control box. Ran on Ground for 32 minuets, found no leaks. Overheat detection self test well. System tested well. Ref TI 4107.2. (Robert Scarlett RU3A796U 12/12/2009 BWI)
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N58
Tail Number: N58
Aircraft Type: LR-60
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Narrative:
VN111 FLYING PILOT. POSITIONED ON THE ADW ARR (INBOUND) AT 6000'. AFTER A 20 MINUTE FLIGHT, DUAL BLD AIR LIGHT INDICATION (TAIL COMPARTMENT OVERHEAT WARNING). EMER/ABNORMAL CHECKLIST COMPLETED AND BLEED AIR SYSTEM ISOLATED (TURNED OFF). LIGHTS REMAINED ILLUMINATED AND PRECAUTIONARY, OVERWEIGHT LANDING MADE AT KBWI. LIGHTS WENT OUT APPROXIMATELY 20 MINUTES AFTER LANDING WHILE BLOCKING INTO FBO.
Phase of Flight:
Flight Phase at Start of Event: Cruise
Cause
Narrative:
BLEED AIR LEAK .
Detection
Aircraft Equipment:

Aircraft Warning/Message System: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Contacted ATC: Yes
Flight Status after Event:
Precautionary Landing: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 367

Overview:
Processing:
Status: Closed
ID: 367
Date/Time When Event Occurred: Mon, 23 Nov 2009 16:30 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Wed, 25 Nov 2009 17:53 Z
Submission Date/Time: Wed, 25 Nov 2009 17:53 Z
Source: Web Submission
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N56
Tail Number: N56
Aircraft Type: LR-60
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Narrative:
Flight checking KJFK ILS 31L glide slope restoral. Executing ILS-2 maneuver, inbound on localizer, 1,600msl. Struck bird on upper 1/3 of windscreen center post. Appeared to be large gull. No apparent damage visible to crew. Returned to KACY to have MX check aircraft. No damage found by MX.
Phase of Flight:
Flight Phase at Start of Event: Holding
Cause
Narrative:
Bird appeared abruptly and there was insufficient time to react.
Detection
How Event Detected:
Self Awareness/Scan: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Status after Event:
Precautionary Landing: Yes
Diversion: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 364

Overview:
Processing:
Status: Closed

ID: 364

Date/Time When Event Occurred: Thu, 29 Oct 2009 12:28 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 29 Oct 2009 17:28 Z

Submission Date/Time: Thu, 29 Oct 2009 17:32 Z

Source: Web Submission

Debrief Narrative: Found metal Fuzz on RH engine chip detector. Cleaned chip detector and tested okay. Ran engine and no repeat of indication found. Operational and leak checks good IAW with P&W maintenance manual.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N77

Tail Number: N77

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Flight Information:

Departure Airport, Runway and Gate: OKC/KOKC

Narrative:

DEPARTED OKC CLIMBING TO FL260. LEVELED AT FL260, EXECUTED CRUISE CHECKLIST AND RIGHT ENGINE CHIP DETECT LIGHT ILLUMINATED. RTB. RAN THE APPROPRIATE CHECKLIST. LANDING WAS UNEVENTFUL.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

*

Detection

Reaction

Narrative:

CHECKED WITH MAINTENANCE AND THEY FOUND A VERY SMALL, ALMOST MICROSCOPIC FOD ON THE CHIP DETECT SENSOR.

Suggestions

Deidentified Crewmembers Analyst SSE Report 363

Overview:

Processing:

Status: Closed

ID: 363

Date/Time When Event Occurred: Mon, 26 Oct 2009 18:30 Z

Local Time When Event Occurred: 10:30

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 27 Oct 2009 17:50 Z

Submission Date/Time: Tue, 27 Oct 2009 17:55 Z

Source: Paper Submission

Debrief Narrative: Discrepancy could not be duplicated.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N84

Tail Number: N84

Aircraft Type: BE-300

Narrative:

Yaw Damp engaged on takeoff roll. Yaw Damp annunciator did not illuminate.

<< Event occurred at PANC >>

Phase of Flight:

Flight Phase at Start of Event: Takeoff

Cause

Narrative:

*

Detection

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 362

Overview:

Processing:

Status: Closed

ID: 362

Date/Time When Event Occurred: Thu, 15 Oct 2009 13:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 15 Oct 2009 11:51 Z

Submission Date/Time: Thu, 15 Oct 2009 11:51 Z

Source: Web Submission

Debrief Narrative: This is an active TAG project <Stuckert>

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Narrative:

During recent MedAire training, discovered that Automated External Defibrillator (AED) was most effective when applied within first 7 minutes after the onset of ventricular fibrillation (VFIB). In fact, the statistics show that the chance of survival is 90% if the AED is immediately applied with a 10% deterioration for every minute delay thereafter. After 7 minutes, survival is unlikely. It is my understanding that Cardio Pulmonary Resuscitation (CPR) is not very effective in changing this survival scenario. Currently, AEDs are only installed on our Challenger fleet. I believe that this is based on the fact that they frequently fly long over water missions which could make ground based medical help unavailable for hours. After the MedAire training, it occurred to me that the AED would be equally useful on our shorter range Kingair and Learjet aircraft. When it comes to AEDs, the argument for its necessity is minutes, rather than hours, 7 minutes in fact. Even if a crewmember is stricken while the aircraft is in a downwind for landing, it is unlikely that ground based help could be applied within 7 minutes from that point. Based on the statistics, to a stricken crewmember with VFIB, 7 minutes or 7 hours without AED treatment results in the same outcome, death. Based on this, I see no more compelling argument to have an AED on a Challenger over any of our other aircraft. Also, it should be noted that our Lear and Kingair fleet are also exposed to long over flight when we cover the Caribbean and Central and South America.

The MedAire training also mentioned some countries that have potentially less than sterile medical facilities. When working the Caribbean, Central and South America, we land in some the countries mentioned. The MedAire kit provides sterile syringes, IVs, and non-expired basic medications. They recommended that a crew use these items rather than the hospital provided ones if landing in a questionable country. The kit also provides very useful items that could be essential for long over water flight. Once again, I think a limited number of these kits would be useful in our Kingair and Lear aircraft that go international, or to remote and isolated areas.

Phase of Flight:

Flight Phase at Start of Event: Non-Flight

Cause

Narrative:

See above and below.

Detection

Reaction

Suggestions

Narrative:

I recommend that AEDs be provided for all AVN aircraft while they are flying.

I recommend that we provide a full MedAire (or equivalent) kit for all AVN aircraft when they are flying international, extended over water, and/or to remote and isolated areas.

I just want to be clear, that I understand that none of this equipment is required by any regulation. Considering that, I greatly appreciate that AVN has purchased the existing equipment and is willing to entertain expanding its use to the rest of the fleet.

Deidentified Crewmembers Analyst SSE Report 361

Overview:

Processing:

Status: Closed

ID: 361

Date/Time When Event Occurred: Thu, 08 Oct 2009 18:37 Z

Local Time When Event Occurred: 14:37

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 08 Oct 2009 20:10 Z

Submission Date/Time: Thu, 08 Oct 2009 20:11 Z

Source: Web Submission

Debrief Narrative: A maintenance discrepancy was noted for a bird strike on the left inboard wing root.

The maintenance action was initiated for the inspection of the leading edge damage in accordance with TI 4128.3, 20-10-03. Damage did not exceed limits. An additional Inspection of the de-ice boot for holes or other damage was conducted. No damage to the de-ice boot was found.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N73

Tail Number: N73

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

During arrival in the Augusta, GA terminal area for flight inspection, PNF (PIC) noted small bird impact on right side of fuselage at cockpit. No abnormal aircraft indications were noted. Upon landing, visual inspection confirmed a small amount of bird debris on top of right wing leading edge near fuselage and smeared down right side of fuselage over right wing. Impact occurred at 2500 MSL (2100 AGL), approximately 185 KIAS, 8.8 nm southeast of KAGS.

No aircraft damage noted.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Bird flew into path of aircraft.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 360

Overview:

Processing:

Status: Closed

ID: 360

Date/Time When Event Occurred: Thu, 01 Oct 2009 20:00 Z

Local Time When Event Occurred: 16:00

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 06 Oct 2009 17:17 Z

Submission Date/Time: Tue, 06 Oct 2009 17:18 Z

Source: Web Submission

Debrief Narrative: Inspection of area found no visible damage. Performed gear swing IAW TI 4128.2 Capt 32-30-00, operational check of gear normal.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N74

Tail Number: N74

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

On Oct. 1, 2009 we were doing a mean wide run to restoring the glide slope at Willow Run, MI Rwy 05R. Two birds were observed and one went up and the other dove and hit the left nose wheel door of the landing gear. There was no disruption noticed, just the noise of the strick. The crew elected to go back to BTL with the gear down and let maintenance make repairs if needed. There was no damage at all just feathers and remains.

****This report is for statistic only. Please do not put it out for crews to read. Thank you!*

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

N/A

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 359

Overview:

Processing:

Status: Closed

ID: 359

Date/Time When Event Occurred: Thu, 01 Oct 2009 17:50 Z

Local Time When Event Occurred: 12:50

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 01 Oct 2009 20:21 Z

Submission Date/Time: Thu, 01 Oct 2009 20:21 Z

Source: Web Submission

Debrief Narrative: Findings:

Maintenance personnel performed a brake bleed maintenance action and then function checked and operationally checked the brakes per TI 4128.2.

Corrective Action:

AVN maintenance removed and replaced the left hand inboard and outboard brake assemblies in accordance with TI4128.2 chapter 32-40-00.

Additional Investigation:

A detailed inspection and discussion with the wheel and brake shop technician performing the subject brake assembly teardown found the mode of brake failure to be excessive heat. Heat damage was visible due to a varied darkening of the brake pack paint. Eleven of the twelve brake assembly O-rings were found to be brittle and deformed due to severe over-heat. The extent and location of the damage to the O-ring correlated with the paint overheat discoloration.

Recommendation:

It is recommended that operational procedures be developed to require brake cooling during ground operations requiring excessive ground breaking.

Prepared by: Mark Whittington, AJW-34122, Ext 5353

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N66

Tail Number: N66

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

During landing rollout on runway 35L at KOKC, the PF applied wheel brakes to stop the aircraft. The left brake pedal went to the floor and provided no braking action on the left wheel. The right wheel brake worked normally. The PF announced to the PNF "Left brake inoperative" and directed the PNF to try his wheel brakes. The PNF confirmed he also had no left wheel brake. The PF maintained directional control, slowed to taxi speed while the PNF alerted the tower controller that we were having brake problems. After stopping the aircraft on the runway, the PF determined that controlling the aircraft with one wheel brake was not prudent and the aircraft was shut down on the runway. ATC coordinated with airfield operations and FAA maintenance, both were dispatched with tug and tow bar and they towed the aircraft to the FAA ramp.

Phase of Flight:

Flight Phase at Start of Event: Rollout Landing

Cause

Narrative:

Aircraft turned over to OKC maintenance to troubleshoot and repair.

Detection

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes
Flight Status after Event:
No Disruption: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 355

Overview:

Processing:

Status: Closed

ID: 355

Date/Time When Event Occurred: Thu, 10 Sep 2009 22:15 Z

Local Time When Event Occurred: 14:15

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 11 Sep 2009 22:14 Z

Submission Date/Time: Fri, 11 Sep 2009 22:15 Z

Source: Web Submission

Debrief Narrative: A review of aircraft maintenance records finds no discrepancy was generated associated with this SSE. Therefore no maintenance corrective was performed associated with this SSE.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N54

Tail Number: N54

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

VN096 PIC (PF), VN061 SIC (PNF), VN094 MS. During TO roll on KLGB RWY 30, simultaneous with V1 callout, TO Warning Horn sounded and PF initiated abort. A/C was stopped with full reverse thrust and, when below 80 KIAS, moderate braking. AC weight was 19,500, SL, 91 F, conditions over Turnaround Weight Limit, but within Landing Wt Limits. Taxied AC to area for 20 minute cooldown and visual inspection. Visual revealed #3 brake hot enough to be smoking. Flight terminated, taxied to FBO and notified SAC FIFO Acting Mgr, Safety Officer/MX and all agreed no limits exceeded and no further mx required. Chief Pilot notified.*

Phase of Flight:

Flight Phase at Start of Event: Rejected Takeoff

Cause

Narrative:

Cause of TO Warning Horn not determined. No annunciator lights were observed during TO roll to support TO Warning System activation. Sim Training teaches activation of TO Warning horn well into TO run should be reason to suspect Thrust Reverser Deployment. No TR lights noted during TO roll.

Upon exiting runway, crew noted trim set outside takeoff position, however this was retrimmed by PF during rollout and taxi. If this had been outside TO range during TO, Warning horn would have sounded immediately upon power application, not at 120+K on TO roll.

Post-flight checks of TO Warning System were normal.

Request made to FOQA Officer to pull FOQA data for pilot education and incident recreation.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:
Corrected Pitch/Power: Yes
Flight Status after Event:
Flight Cancellation: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 354

Overview:
Other Employees:
Employee Duty: Pilot Flying
Employee Number: VN077
First Name: Marc
Last Name: Hinc
Other Employees:
Employee Duty: Mission Specialist
Employee Number: VN142
First Name: Charles
Last Name: Rice
Processing:
Status: Closed
ID: 354
Aware Date/Time: Tue, 01 Sep 2009 21:30 Z
Date/Time When Event Occurred: Tue, 01 Sep 2009 21:30 Z
Local Time When Event Occurred: 17:30
Viewer Accessible: Yes
Initial Notification Date/Time: Wed, 02 Sep 2009 13:17 Z
Submission Date/Time: Wed, 02 Sep 2009 13:18 Z
End of Trip Date/Time: Tue, 01 Sep 2009 22:00 Z
Source: Web Submission
Debrief Narrative: Findings:
AVN personnel performed a left hand wing inspection and found a broken MH374A22 wire at the MP4 plug.

Corrective Action:
The damaged wire was repaired and the Air Conditioning blower was successfully function tested.

Additional Investigation:
None.

Recommendation:
None.

Prepared by: Mark Whittington, AJW-34122, Ext 5353
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N73
Tail Number: N73
Aircraft Type: BE-300
Speed IAS (Knots): 195
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Flight Information:
Departure Airport, Runway and Gate: AHN/KAHN - 09/27

Flight Number: FLC 73

Time of Day: Daylight

Scheduled Arrival Airport, Runway and Gate: FTY/KFTY - 08/26

Landing Airport, Runway and Gate: FTY/KFTY - 08/26

Filed Altitude (MSL): 3000

Narrative:

All airflow in aircraft ceased. Cabin became warm. Faint odor of a duct overheating however, bleed air fail light/s did not illuminate. Odor diminished after a few minutes. Found environmental "Temp" CB popped.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Weather:

Meteorological Conditions: IMC

Cause

Narrative:

N/A

Detection

Narrative:

Ambient temperature increase and faint duct type odor.

Reaction

Narrative:

Turned Cabin Temp Mode (airconditioning) and vent blowers off. Placed bleed air valves switches to enviroff. Event occurred at 3,000 msl 30 NM from landing at KFTY (original destination). Uneventful landing. Taxied aircraft to hangar.

Suggestions

Narrative:

N/A

Deidentified Crewmembers Analyst SSE Report 349

Overview:

Processing:

Status: Closed

ID: 349

Date/Time When Event Occurred: Wed, 26 Aug 2009 21:20 Z

Local Time When Event Occurred: 16:20

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 26 Aug 2009 22:57 Z

Submission Date/Time: Wed, 26 Aug 2009 22:58 Z

Source: Web Submission

Debrief Narrative: No log book entry, no maintenance action. See log book pages 106354 & 106355

Fortunately the event did not meet the requirements for either engine or propeller sudden stoppage or impact maintenance requirements.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N72

Tail Number: N72

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Narrative:

On approach to RWY 19L at KICT, hawk hit left propeller. Felt thud but no degradation or vibration, etc. after impact. Continued approach and landed normally. Post flight inspection of remains appeared to confirm prop impact. No damage was evident.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Bird spotted with insufficient space to avoid. Abrupt maneuver at low altitude and airspeed would have been required.

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Maintenance: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Narrative:

None.

Deidentified Crewmembers Analyst SSE Report 346

Overview:

Processing:

Status: Closed

ID: 346

Date/Time When Event Occurred: Wed, 19 Aug 2009 15:30 Z

Local Time When Event Occurred: 11:30

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 19 Aug 2009 19:35 Z

Submission Date/Time: Wed, 19 Aug 2009 19:35 Z

Source: Web Submission

Debrief Narrative: A metallurgical analysis was performed on the failed line. The failure was due to stress corrosion cracking in an area of high tensile stress. This was a single event failure with no trends in the fleet.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N55

Tail Number: N55

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

VFR, landing rwy 35 KMHT. Selected gear down in right downwind. Observed flashing hydraulic pressure low lights. Landing gear extended down with normal indications. Time to extend was longer than normal. Hydraulic low pressure lights extinguished. Hydraulic pressure gage showed normal pressure. Now in base to final turn. Hydraulic lights illuminated intermittently again then stayed on. Hydraulic pressure gage still showing normal. Elected to execute go-around to run abnormal checklist. Configuration remained flaps 20 deg with gear down. Requested delay vectors from atc and declared emergency. Ran appropriate abnormal checklists, briefed for possible loss of brakes, spoilers, and TRs on landing. Prepared for use of emergency brake system. Continued for landing KMHT rwy 35. Selected and obtained full flaps on final. Hydraulic low press lights remained illuminated but hydraulic pressure gage still showed normal pressure. Continued to landing and then found normal brakes failed shortly after touchdown. Hydraulic pressure gage dropped into the low end of the yellow range at this point. Conducted uneventful stop well short of rwy end using emergency braking. Spoilers and TRs were unavailable.

Phase of Flight:

Flight Phase at Start of Event: Landing

Cause

Narrative:

Maintenance inspection after landing found failed hydraulic line in fuselage abeam the main landing gear. It should be noted that the mechanic informed me that he found both the left and right inboard main gear door actuator switches were loose and not safety wired. It is not known if this was contributing to the hydraulic line failure.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Declared Emergency with ATC: Yes

Executed Go Around: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Narrative:

Cause of failure of the hydraulic line is unknown at this time.

Deidentified Crewmembers Analyst SSE Report 348

Overview:

Processing:

Status: Closed

ID: 348

Date/Time When Event Occurred: Wed, 19 Aug 2009 15:18 Z

Local Time When Event Occurred: 11:18

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 19 Aug 2009 20:39 Z

Submission Date/Time: Wed, 19 Aug 2009 20:39 Z

Source: Web Submission

Debrief Narrative: Correction

-- Replaced engine driven low pressure fuel pump IAW TI4128.2 chpt 28-20-00. Operational and leak check satisfactory.. P/N off RG34720F, S/N B-7170, P/N on RG34720A, S/N B-2866.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N79

Tail Number: N79

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

During flight inspection of KNQX PAR, left fuel pressure low annunciator illuminated in flight. Bold face immediate action items completed. Fuel pressure light extinguished upon actuation of left standby boost pump. Action items backed up with use of "Fuel Pressure Low" emergency checklist. Non-eventful landing followed at KNQX.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

Suspected failure of engine-driven low pressure fuel pump.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:
In-Flight: Yes
Reaction
Flight Status after Event:
Precautionary Landing: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 344

Overview:
Processing:
Status: Closed
ID: 344
Date/Time When Event Occurred: Fri, 07 Aug 2009 13:54 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Fri, 07 Aug 2009 17:53 Z
Submission Date/Time: Fri, 07 Aug 2009 17:53 Z
Source: Web Submission
Debrief Narrative: This incident did not result in a maintenance discrepancy. No maintenance action was associated with this event.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N86
Tail Number: N86
Aircraft Type: CL-601
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot
Narrative:
Immediately following rotation on initial take off, Rwy 22, KSPI, a small bird struck the upper, left, pilot's windscreen. Observed no abnormal engine indications. Continued climb out and proceeded to holding pattern. Advised ATC and contacted KSPI tower. Tower had airfield operations conduct a runway FOD inspection and found a small starling approximatel midfield, centerline of the runway. Continued mission with no further negative impact.

Recommended that KSPI tower advise traffic of increased bird activity and to take caution.

Phase of Flight:
Flight Phase at Start of Event: Initial Climb
Cause
Narrative:
n/a
Detection
How Event Detected:
Self Awareness/Scan: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Contacted ATC: Yes
Flight Status after Event:
No Disruption: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 343

Overview:

Processing:

Status: Closed

ID: 343

Date/Time When Event Occurred: Tue, 21 Jul 2009 16:30 Z

Local Time When Event Occurred: 11:30

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 21 Jul 2009 22:51 Z

Submission Date/Time: Tue, 21 Jul 2009 22:52 Z

Source: Web Submission

Debrief Narrative: Crewmember removed bird from main air conditioning inlet screen. This incident did not result in a maintenance discrepancy. No maintenance action was associated with this event.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N73

Tail Number: N73

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

Hit small (3 inch) bird on 3 mi final prior to landing Rwy 13 KFOE. The bird was trapped by the screen on the input side of the main air conditioner condenser blower (right side of nose). Bird remains were removed with a leatherman tool.

Phase of Flight:

Flight Phase at Start of Event: Approach

Cause

Narrative:

There were a large number of birds on the final approach course. ATC had issued a bird warning prior to the bird strike.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Narrative:

None offered, as bird flight paths are unpredictable. Bird strikes are an occupational hazard.

Deidentified Crewmembers Analyst SSE Report 335

Overview:

Processing:

Status: Closed

ID: 335

Date/Time When Event Occurred: Tue, 09 Jun 2009 19:15 Z

Local Time When Event Occurred: 12:15

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 11 Jun 2009 00:45 Z

Submission Date/Time: Thu, 11 Jun 2009 00:45 Z

Source: Web Submission

Debrief Narrative: Corrective Action: Defective Nosewheel Steering computer was replaced with an FAA supplied unit by the KPDX FBO; Global Aviation.

Additional Investigation: A review of the ILM entries for the LJ 60 fleet for the word "Nosewheel Computer" revealed a total of 34 nosewheel steering related discrepancies in the LJ60 fleet since July of 2002.

11 of these have occurred on N54 (32%).

The Nosewheel Steering computer was last replaced on N54 in March, 2007.

Only 5 computers have been replaced in the fleet and these were on N54 and N59 only.

As a result of this ILM review, maintenance does not see a trend in this type of failure.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N54

Tail Number: N54

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

Upon gear extension during final approach to KPDX, pilot not flying noticed the nosewheel steering failed to arm. Crew verified annunciator was operational and visually verified that the nosewheel steering CBs had not popped. Crew followed procedures for Nosewheel Steering Malfunction in Flight IAW abnormal checklist and landed uneventfully. Rudder deflection and differential braking were used to exit the runway IAW Checklist. Crew elected to stop aircraft on apron and coordinated to have aircraft towed to FBO.

Phase of Flight:

Flight Phase at Start of Event: Landing

Cause

Narrative:

Initial indication is faulty nosewheel steering computer.

Detection

How Event Detected:

Flight Crew: Yes

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Landed in Emergency Condition: Yes

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Narrative:

Nosewheel steering computer is being replaced 6/10/09.

Deidentified Crewmembers Analyst SSE Report 333

Overview:

Processing:

Status: Closed

ID: 333

Date/Time When Event Occurred: Wed, 27 May 2009 15:35 Z

Local Time When Event Occurred: 11:35

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 28 May 2009 18:28 Z

Submission Date/Time: Thu, 28 May 2009 18:28 Z

Source: Web Submission

Debrief Narrative: Findings:

Inspection by maintenance personnel found the ground idle solenoid bracket not securely clamped.

Corrective Action:

AVN maintenance secured the clamp to prevent ground idle solenoid slippage.

Additional Investigation:

The maintenance rigging team performed additional inspection and adjustment of the prop pitch system. It was found that a newly procured Beech manufactured solenoid clamp assembly failed to properly secure the solenoid when fully tightened. At present an investigation of the faulty component is being pursued by program standards engineering. This investigation has begun with an evaluation for the cause for faulty components procured from Beech Craft. In addition a pull gauge test procedure is being evaluated to identify faulty solenoid clamps and installations. If deemed practical this procedure will be included in the engine rigging procedures.

Follow-up Remarks:

This incident is the second of two for this aircraft within a month. The corrective action for earlier incidents has been the implementation of dedicated engine rigging teams which are utilized when the engine rigging is in any disturbed. The implementation of this practice has yielded an improvement in the un-commanded prop pitch ground idle occurrence. However a class of new contributing factors for this situation has been identified as a result of the investigation of the N-70 incidents. This new class of contributing factors is non-conforming manufacturer provided components. The earlier N-70 incident identified Beechcraft provided solenoid brackets which did not adequately secure the clamp to the reversing wire rope. Subsequent to the initial investigation of the second N-70 incident an additional investigation was conducted regarding suspect propeller beta ring feedback rods installed on the propeller assembly. An on site inspection of the propeller rework facility found that the guide rods were out of tolerance and therefore causing binding of the prop pitch assembly.

The engine rigging team has now incorporated inspection procedures to verify that solenoid attachment brackets installed on FAA Flight Inspection Beechcraft aircraft provide a secure fit at each rigging check. In addition a maintenance review board action No. 090503 has been issued requiring a beta ring feedback rod confidence test of propeller assemblies during the receiving inspection process.

Prepared by: Mark Whittington, AJW-34122, Ext. 5353

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N70

Tail Number: N70

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

Leonard Burger (PIC), Brent Booker (SIC), and William Frankowski (MS) while conducting TAC periodic flight check at Mayport NAS, Jacksonville, FL experienced right engine flat pitch prop immediately prior to touchdown on RWY 05 following Copter Tacan RWY 5 approach. Aircraft yawed fifteen to twenty degrees right of runway centerline, main gear touched pavement as go around was executed, a brief exciting ride was had by all but aircraft control was promptly regained with remainder of climbout uneventful. A simulated landing was accomplished at altitude with identical result (flat pitch prop--yaw to right). The master caution illuminated both times. Prop pitch light did not illuminate either time. The mission was terminated, ATC was advised and full stop landing was requested at Jacksonville International. Fire fighting equipment was requested to stand by. The approach was flown at 1500 RPM with plan not to change the prop RPM prior to landing. Sufficient power was applied to maintain the props on the governor through touchdown. A full stop landing was accomplished with no further incident. The aircraft was taxied to the FBO without incident. Brent Booker stated his belief that any other action during the attempted landing at Mayport would have resulted with the aircraft in the grass. The crew concurs.

Phase of Flight:

Flight Phase at Start of Event: Landing Flare

Cause

Narrative:

This event has occurred previously with this aircraft. There has been no reason offered as to why in the past and I offer no reason why for this occurrence.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Contacted Company: Yes

Contacted Maintenance: Yes

Executed Go Around: Yes

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Narrative:

Ground this aircraft until the problem is unequivocally determined. Have this aircraft investigated by Beechcraft engineers.

Consideration should be given to checklist procedure following a go around following one of these occurrences.

Deidentified Crewmembers Analyst SSE Report 332

Overview:

Processing:

Status: Closed

ID: 332

Date/Time When Event Occurred: Thu, 21 May 2009 18:22 Z

Local Time When Event Occurred: 13:22

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 22 May 2009 11:51 Z

Submission Date/Time: Fri, 22 May 2009 11:51 Z

Source: Web Submission

Debrief Narrative: Findings:

Inspection by maintenance personnel found the right bleed air fail switch and found the EVA tubing loss near the pneumatic manifold.

Corrective Action:

AVN maintenance replaced replaced defective switch and tightened loose tubing.

Additional Investigation:

A review of reliability data associated with Be-300 engine bleed air system finds this discrepancy to be the result normal in-service discrepancies.

Prepared by: Mark Whittington, AJW-34122, Ext 5353

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N71

Tail Number: N71

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

While performing ILS 2 maneuvers at KRST, the R BLEED AIR FAIL annunciator illuminated. The Emergency checklist was called for and completed successfully. The crew elected to land at KRSt after discussion. The landing was uneventful.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Landed in Emergency Condition: Yes

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 330

Overview:

Processing:

Status: Closed

ID: 330

Date/Time When Event Occurred: Tue, 12 May 2009 14:30 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Wed, 13 May 2009 14:30 Z

Submission Date/Time: Wed, 13 May 2009 19:56 Z

Source: Paper Submission

Debrief Narrative: Findings:

Inspection by maintenance personnel could not duplicate the discrepancy.

Corrective Action:

After extensive consultation with the engine manufacture, the fuel dump valve was cleaned.

Additional Investigation:

This issue was extensively evaluated by Pratt & Whitney technical support. No exceedences were logged by the engine download data. It was determined that the failed start was probably due to a temporarily stuck fuel dump valve.

Prepared by: Mark Whittington, AJW-34122, Ext 5353

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N54

Tail Number: N54

Aircraft Type: LR-60

Narrative:

WHILE ATTEMPTING TO START #2 ENGINE, INITIAL INDICATIONS WERE NORMAL. ITT THEN RAPIDLY ACCELERATED TO 850 DEGREES AND STABILIZED. ITT THEN FLUCTUATED BETWEEN 870 AND 890 DEGREES. N1 - 8%, N2 - 12%, FUEL FLOW NORMAL, OIL TEMPERATURE NORMAL, OIL PRESSURE - 15 PSI. START WAS TERMINATED AND MAINTENANCE ADVISED.

Phase of Flight:

Flight Phase at Start of Event: Engine Start/Pushback

Cause

Narrative:

*

Detection

How Event Detected:

Self Awareness/Scan: Yes

Reaction

Flight Crew:

Contacted Maintenance: Yes

Engine Shutdown: Yes

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 329

Overview:

Processing:

Status: Closed

ID: 329

Date/Time When Event Occurred: Wed, 06 May 2009 12:15 Z

Local Time When Event Occurred: 08:15

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 07 May 2009 03:01 Z

Submission Date/Time: Thu, 07 May 2009 03:01 Z

Source: Web Submission

Debrief Narrative: Corrective Action: Replace wick when N79 returns to home station.

Prepared by: Thomas Solinski, AJW-3452, Ext 46240, 5/7/09

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N79

Tail Number: N79

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Other

Narrative:

Raleigh, NC (KRDU), TAC-AIR FBO: Approached FBO business counter, payed for fuel, and requested that N79 be pulled out of hanger and brought up on line for preflight and departure. While performing other pre-flight duties, I was approached by Ms Teresa Yates, General Manager of TAC-AIR. She advised me that while removing N79 from the hanger, a TAC-AIR employee had broken the left wing static wick. She was very apologetic, and advised that TAC-AIR assumed full responsibility, and would be glad to repair the damaged static wick. I thanked her and advised that I would report the incident to the FICO, and that FICO maintenance would determine what action to take, and that they would call her shortly. The FICO later determined that an MEL would be issued, and after receiving the MEL, we departed Raleigh and continued our itinerary.

Phase of Flight:

Flight Phase at Start of Event: Towing

Cause

Narrative:

The FBO General Manager, Ms Yates, advised me that the TAC-AIR employee had failed to follow established procedure for removing aircraft from hanger.

Detection

How Event Detected:

Maintenance Personnel: Yes

When Event Detected:

PreFlight: Yes

Reaction

Flight Crew:

Contacted Maintenance: Yes

Flight Status after Event:

Flight Delay: Yes

Suggestions

Narrative:

Ms Yates was very gracious and professional. I have no doubt that, prior to speaking with me, she had already made arrangements for additional training for TAC-AIR employees.

Deidentified Crewmembers Analyst SSE Report 325

Overview:

Processing:

Status: Closed

ID: 325

Date/Time When Event Occurred: Thu, 30 Apr 2009 22:18 Z

Local Time When Event Occurred: 11:18

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 04 May 2009 13:54 Z

Submission Date/Time: Mon, 04 May 2009 13:54 Z

Source: Web Submission

Debrief Narrative: Findings:

Inspection by maintenance personnel found the ground idle solenoid bracket not securely clamped.

Corrective Action:

AVN maintenance secured the clamp to prevent ground idle solenoid slippage.

Additional Investigation:

The maintenance rigging team performed additional inspection and adjustment of the prop pitch system. It was found that a newly procured Beech manufactured solenoid clamp assembly failed to properly secure the solenoid when fully tightened. At present an investigation of the faulty component is being pursued by program standards engineering. This investigation has begun with an evaluation for the cause for faulty components procured from Beech Craft. In addition a pull gauge test procedure is being evaluated to identify faulty solenoid clamps and installations. If deemed practical this procedure will be included in the engine rigging procedures.

Prepared by: Mark Whittington, AJW-34122, Ext. 5353

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N70

Tail Number: N70

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Narrative:

W. TYRE PIC (NOT FLYING) , W. COOPER SIC (FLYING), S. HERMAN MS. ON LANDING AT KBNA THE RIGHT PROP PITCH WENT BELOW THE FLIGHT IDLE STOP DURING THE FLARE. AIRCRAFT CONTROL WAS MAINTAINED FOLLOWED BY AN UNEVENTFUL LANDING.

Phase of Flight:

Flight Phase at Start of Event: Landing Flare

Cause

Narrative:

N-70 HAD THE RIGHT PROP CHANGED PRIOR TO DEPARTING 4/29/09 ON A FLIGHT INSPECTION ITINERARY.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Maintenance: Yes

Override Automation: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 316

Overview:

Processing:

Status: Closed

ID: 316

Date/Time When Event Occurred: Thu, 19 Mar 2009 14:30 Z

Local Time When Event Occurred: 10:30

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 19 Mar 2009 15:27 Z

Submission Date/Time: Thu, 19 Mar 2009 15:27 Z

Source: Web Submission

Debrief Narrative: Findings:

Inspection by maintenance personnel found the number 2 engine had seized due to oil starvation.

Corrective Action:

AVN maintenance replaced the failed engine.

Additional Investigation:

A review of reliability data associated with Be-300 engine seizure finds this discrepancy to be the result of a previous maintenance action, which resulted in failure to properly tighten an oil line.

Prepared by: Mark Whittington, AJW-34122, Ext 5353

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N66

Tail Number: N66

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Narrative:

While performing engine start procedures IAW Starting Engines/Battery Checklist, observed normal engine start on #2 (Right) engine, followed by normal engine start on #1 (Left) engine, followed by R OIL PRESS Master Warning Annunciator illumination. Verified zero

oil pressure indication on #2 Engine Oil Pressure Gauge. Right seat pilot performed visual scan of #2 engine, and observed significant oil leak. Performed engine shut-down of both engines. Observed #2 propeller seize. Crew evacuated aircraft and notified maintenance.

Phase of Flight:

Flight Phase at Start of Event: Engine Start/Pushback

Cause

Narrative:

Unknown.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

Ramp: Yes

Reaction

Flight Crew:

Engine Shutdown: Yes

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 309

Overview:

Processing:

Status: Closed

ID: 309

Date/Time When Event Occurred: Fri, 13 Feb 2009 23:00 Z

Local Time When Event Occurred: 15:00

Viewer Accessible: Yes

Initial Notification Date/Time: Sat, 14 Feb 2009 00:33 Z

Submission Date/Time: Sat, 14 Feb 2009 01:00 Z

Source: Web Submission

Debrief Narrative: Corrective Action: ILM entry 2/13/09: -- ADJUSTED RIGHT SIDE MAIN GEAR UP LIMIT SWITCH IAW TI 4128.2, CHAP.32, OPS CHECK GOOD

Additional Investigation: None required- CLOSED 2/24/2009

Prepared by: Thomas Solinski, AJW-3452, Ext 46240

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N83

Tail Number: N83

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

During cruise flight at FL260 at about 210 KIAS, the landing gear warning light (gear handle) illuminated. There were no other indications of problems with the landing or hydraulic system. A system review and checklist review was done by the crew and the FICO was advised while in cruise flight, with the request made to advise SMF maintenance. During the descent, at approximately FL180, the light extinguished on its own. The landing gear extended normally and a normal landing was made. .

Cause

Narrative:

Later investigation by maintenance determined a right landing gear microswitch was slightly out of adjustment.

Detection
Aircraft Equipment:
Aircraft Warning/Message System: Yes
When Event Detected:
In-Flight: Yes
Reaction
Flight Crew:
Contacted Company: Yes
Contacted Maintenance: Yes
Contacted Operations: Yes
Flight Status after Event:
No Disruption: Yes
Suggestions

Deidentified Crewmembers Analyst SSE Report 305

Overview:
Processing:
Status: Closed
ID: 305
Date/Time When Event Occurred: Thu, 12 Feb 2009 20:00 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Thu, 12 Feb 2009 20:17 Z
Submission Date/Time: Thu, 12 Feb 2009 20:18 Z
Source: Web Submission
Debrief Narrative: Findings:
After landing the right outboard landing gear door was found to be hanging loose and broken.

Corrective Action:
AVN maintenance removed and replaced the door hinge assembly and actuator bracket.

Additional Investigation:
a reliability program evaluation of similar system failures does not find a trend in landing gear failures of this nature. An additional Program Standards Engineering inspection of the failed components finds that the landing gear door actuator may have initiated the door failure. At this time the possible need for an inspection of the landing gear door actuator bracket is being considered. Should an inspection be deemed necessary, a MAB will be issued.

Prepared by: Mark Whittington, AJW-34122, Ext 5353

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N56

Tail Number: N56

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

After landing at KOKC after returning for maintenance on our AFIS equipment, we were advised by maintenance personell that the right outboard landing gear door was hanging loose with broken attachment hardware. Both the retraction rod mount and the hinge bracket had broken. Only one attachment point on the hinge was left holding the door on.

Phase of Flight:

Flight Phase at Start of Event: Parked

Cause

Narrative:

Have no idea why this event occurred. We had been flying the aircraft for three days and had not experienced any unusual vibrations or events that might account for the condition. We had conducted about six gear extensions on the date of discovery. The gear had not been operated at speeds in excess of the allowable and no vibrations or noises had been observed. There were no signs that the door had been open in flight with the gear up, and even though the door was lying against the tire there was no sign that it had been rubbing for any length of time.

Detection

How Event Detected:

Maintenance Personnel: Yes

When Event Detected:

PostFlight: Yes

Reaction

Flight Crew:

Contacted Maintenance: Yes

Flight Status after Event:

No Disruption: Yes

Suggestions

Narrative:

Can't believe that all of this damage occurred during this flight, so suspect that the piano hinge was damaged or broken prior to flight. If that were the case then we should have discovered some damage during preflight. We will check closer in the future and suggest that other do the same.

Deidentified Crewmembers Analyst SSE Report 304

Overview:

Processing:

Status: Closed

ID: 304

Date/Time When Event Occurred: Mon, 09 Feb 2009 15:45 Z

Local Time When Event Occurred: 10:45

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 10 Feb 2009 02:50 Z

Submission Date/Time: Tue, 10 Feb 2009 21:45 Z

Source: Web Submission

Debrief Narrative: Findings: Loose Reservoir Cap

Corrective Action: From ILM entry dated 2/9/09: FOUND HYD RESERVIOR CAP LOOSE. NO FLUID LOSS. RESECURED CAP, RETRACTED GEAR NUMEROUS TIMES WITH NO ILLUMINATION OF LOW LIGHT. LIGHT TEST GOOD. SYSTEM APPEARS NORMAL AS CHECKED IAW TI4128.2 CHAP 32

Additional Investigation: Reviewed Hyd system and cap installation, no further action recommended. CLOSED 2/24/2009.

Prepared by: Thomas Solinski, AJW-3452, Ext 46240

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N75

Tail Number: N75

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

At approximately 1545Z, 15nm from GQO VTAC enroute to KCSV. During Climb to 14000ft, Hyd low light illuminated. Crew made a turn back to base KFTY, after informing ATC. About 3 minutes after the turn the warning Lt extinguished. Crew backed up situation with the abnormal checklist. On extended final, using the before landing checklist, crew noted

a nose gear unsafe indication. The checklist was followed, ending in a landing with a three green down an locked indication , without further problems. Aircraft returned to MX for disposition. Crew completed mission using a back up aircraft.

Phase of Flight:

Flight Phase at Start of Event: Climb

Cause

Narrative:

Cause, unknown at this time, waiting for MX outcome.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Narrative:

Waiting for MX findings.

Deidentified Crewmembers Analyst SSE Report 303

Overview:

Processing:

Status: Closed

ID: 303

Date/Time When Event Occurred: Fri, 06 Feb 2009 00:00 Z

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 06 Feb 2009 16:02 Z

Submission Date/Time: Mon, 09 Feb 2009 13:37 Z

Source: Paper Submission

Debrief Narrative: Findings: Leaking tubing.

Corrective Action: -- FOUND HOLE IN PVC LINE IN LH WHEEL WELL. REPAIRED LINE. OPS CHECKS GOOD

Additional Investigation: None required, CLOSED

Prepared by: Thomas Solinski, AJW-3452, Ext 46240

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N74

Tail Number: N74

Aircraft Type: BE-300

Narrative:

While setting up for the FCM VOR ARR at 6000 feet MSL, the Left Bleed Air Fail Light illuminated. SIC turned left bleed air valve switch to Pneumatic and Environmental Off IAW the Emergency Checklist. Other engine instruments were checked normal. Crew analyzed the impact and decided to terminate the flight inspection mission and that it was safe to return the aircraft back to BTL. Filed an IFR flight plan from FCM to BTL at 13,000 feet MSL. Cabin altitude climbed and stayed at 2500 feet MSL with one bleed operating. Bleed air light extinguished after turning switch off, illuminated again in climb to 13,000, and extinguished in descent for landing. Landing was uneventful.

Cause

Narrative:

*

Detection
Reaction
Suggestions

Deidentified Crewmembers Analyst SSE Report 302

Overview:
Processing:
Status: Closed
ID: 302
Date/Time When Event Occurred: Tue, 03 Feb 2009 21:00 Z
Viewer Accessible: Yes
Initial Notification Date/Time: Thu, 05 Feb 2009 21:46 Z
Submission Date/Time: Thu, 05 Feb 2009 21:51 Z
Source: Paper Submission
Debrief Narrative: Corrective Action: -- ILM entry 2/4/09: Removed and Replaced #1 Inverter & A.C monitor Box, IAW 4128.2 chpt 24.
Ops ck normal, Ok for service,
Additional Investigation: None required, CLOSED

Prepared by: Thomas Solinski, AJW-3452, Ext 46240

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N84

Tail Number: N84

Aircraft Type: BE-300

Narrative:

165 miles S/SW of PANC.

#1 inverter showed fault. Reset Master Warning. Switched inverters to #2. Master Warning annunciator would not extinguish.

Cause

Narrative:

*

Detection

How Event Detected:

Self Awareness/Scan: Yes

When Event Detected:

In-Flight: Yes

Reaction

Suggestions

Deidentified Crewmembers Analyst SSE Report 296

Overview:

Processing:

Status: Closed

ID: 296

Date/Time When Event Occurred: Fri, 16 Jan 2009 16:45 Z

Local Time When Event Occurred: 10:54

Viewer Accessible: Yes

Initial Notification Date/Time: Fri, 16 Jan 2009 19:37 Z

Submission Date/Time: Fri, 16 Jan 2009 19:37 Z

Source: Web Submission

Debrief Narrative: Findings:

14th stage bleed air valve was found to be leaking. The 10th stage bleed air valve clamp was found to be leaking. Two left 10th stage bleed air detect overheat loops were found to have to high a resistance.

Corrective Action:

All faulty components were replaced and the bleed air system was leak tested and ops checked.

Additional Investigation:

An ILM database search was conducted for similar system problems on the challenger fleet. Several bleed air related discrepancies were found over the life of the aircraft, but determined to be within a normal service failure rate. A Program Standards Engineering review of the fault isolation process and corrective actions taken was conducted as well. The corrective actions taken to stop all bleed air leaks and the replacement of the bleed air leak detection components are deemed to be a very thorough steps in addressing this issue.

Prepared by: Mark Whittington, AJW-34122, Ext 5353

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N85

Tail Number: N85

Aircraft Type: CL-601

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

At Cruise FL350, the bleed air leak detect light (center panel) intermittently began flashing. We noticed that the left 10th stage "dolls eye" was tripped. Initially, we did not get the left 10th stage duct fail light. We called the FICO/MX and elected to return to OKC. We began a descent to a lower altitude (FL200 then FL110) to run the checklist. We accomplished the 10th stage duct fail checklist. Per the checklist the left 10th stage was selected off, isolation v closed. While returning to OKC, we configured to burn off fuel to get down to landing wt. We noticed that the bleed air leak detect light (center panel) illuminated and the left 10th stage duct fail light was illuminated. Per the checklist, the left engine was retarded to idle. We accomplished a 20 flap single engine (left throttle in idle) approach and landing.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Call FICO MX for the details on the repairs.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Operated in Degraded Conditions: Yes

Flight Status after Event:

Precautionary Landing: Yes

Air Turnback: Yes

Diversion: Yes

Flight Cancellation: Yes

Suggestions

Deidentified Crewmembers Analyst SSE Report 293

Overview:

Processing:

Status: Closed

ID: 293

Date/Time When Event Occurred: Thu, 15 Jan 2009 20:36 Z

Local Time When Event Occurred: 15:36

Viewer Accessible: Yes

Initial Notification Date/Time: Thu, 15 Jan 2009 22:07 Z

Submission Date/Time: Thu, 15 Jan 2009 22:07 Z

Source: Web Submission

Debrief Narrative: Findings:

Inspection by maintenance personnel found the Copilot windshield delaminated.

Corrective Action:

AVN maintenance replaced the windshield.

Additional Investigation:

A review of reliability data associated with Be-300 windshields finds this discrepancy to be infrequent and therefore require no additional action at this time.

Prepared by: Mark Whittington, AJW-34122, Ext 5353

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N66

Tail Number: N66

Aircraft Type: BE-300

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Flying

Narrative:

Pilot not flying, Robert F. Staake, VN159, noticed enlarged area of delamination in lower left corner of right windshield. Flight was about 50 nm northwest of Battle Creek, MI, at FL 230 when the problem was noticed. Flight diverted to Battle Creek, MI, uneventfully.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Unknown.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted ATC: Yes

Contacted Company: Yes

Contacted Maintenance: Yes

Flight Status after Event:

Diversion: Yes

Suggestions

Narrative:

Event is infrequent, but not unprecedented.

Deidentified Crewmembers Analyst SSE Report 299

Overview:

Processing:

Status: Closed

ID: 299

Date/Time When Event Occurred: Wed, 14 Jan 2009 05:00 Z

Local Time When Event Occurred: 22:00

Viewer Accessible: Yes

Initial Notification Date/Time: Tue, 20 Jan 2009 16:30 Z

Submission Date/Time: Tue, 20 Jan 2009 16:30 Z

Source: Web Submission

Debrief Narrative: Investigation: A detailed record search and review was conducted for the maintenance records associated with this incident. In addition a review of the preflight safety check associated with tire pressure was conducted. Interviews were also conducted with ramp personnel responsible for preflight safety checks. A historical review of the maintenance records for all Flight Inspection Fleet Lear 60 tire assemblies was also conducted.

Findings: The maintenance records search found both of these wheel assemblies were recently installed on this aircraft. Records also indicated that these tires were reworked at the Oklahoma City wheel and brake shop. A review of the preflight safety check task card found the tire pressure check to consist of a visual examination. The visual inspection of the tire pressure is a result of the low volume of the Lear tire assemblies. Therefore a preflight tire pressure gage check is normally unfeasible. This is due to the significant loss of tire pressure, which occurs during each gage check. Each tire gage check requires the presence of a nitrogen cart to restore proper tire pressure. The review of all Flight Inspection Fleet Lear 60 tire discrepancies for the last 3 + years found the three reasons for tire assembly failure to be, tire wear or scheduled maintenance (87.8%), overweight landing (7.5%) and tire leakage (4.7%). The causes for failure to hold pressure are: Fuse plug O-rings, wheel assembly O-rings and failure of the tire beads to seal.

Recommendations: With the finding of two fuse plugs under torqued on the same plane and on recently changed tires which were also reworked at the same rework facility, a review of the rework facility is warranted. Therefore the Flight Program Continued Analysis and Surveillance program should be implemented, initiating the following actions in the Oklahoma City Tire and Brake shop:

1. Spot check of Lear 60 tire assembly recently reworked.
2. Audit of Lear 60 tire assembly rework procedures and evaluate any need for additional quality verification processes.
3. Review of Lear 60 tire assembly rework written procedures.
4. Inspection of calibrated tooling utilized to rework and assemble tire assemblies.

Point of contact is Mark Whittington, Aerospace Engineer, AJW-345, Ext 4-5353

NOTE: AJW-311 asked that this SSE not be closed yet.

Closed 06/15/10 by Operations -- Tire pressure required to be checked every 96 hours.

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:

Risk Factor:

Description

Aircraft Configuration:

Nickname: N55

Tail Number: N55

Aircraft Type: LR-60

Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot

Narrative:

During preflight on the night of Jan 14 at 22:00 local time we found the tire pressures low on the left main landing gear. We had flown the aircraft to Denver the preceding day and had not noticed this condition. The aircraft had been flown earlier in the day by a Sacramento, California crew and then refueled for us so it was quite heavy. Perhaps that is what made it so apparent. It was obvious

that the tires were too low for the aircraft to be flown. The problem was taken care of the next day by a Mayo Aviation maintenance crew.

Phase of Flight:

Flight Phase at Start of Event: Predeparture/Preflight

Cause

Narrative:

The Mayo crew reported that both tires had had only 75lbs of pressure, and that they had found the fuse plugs to be only finger tight and leaking. Also they showed us a wheel bearing that they had removed from one of the units that had a bent race. They replaced both tires, bearings and fuseplugs.

Detection

How Event Detected:

Flight Crew: Yes

When Event Detected:

PreFlight: Yes

Reaction

Flight Crew:

Contacted Company: Yes

Contacted Maintenance: Yes

Contacted Operations: Yes

Flight Status after Event:

Flight Cancellation: Yes

Suggestions

Narrative:

I feel that we need the following things:

1) The tire and wheel shop should pay a little more attention to detail.

2) We need line crews to pay better attention to tire pressures.

3) We need flight crews to be able to check the pressure in the tires during preflight while on the road. I suggest that we put a airpressure gague on board the aircraft sothat tire pressure can be verified by the crews.

Tire pressure is critical on the Lear. It is quite high (208lbs) and the limits are narrow. They are small wheels supporting lots of weight at very high speeds.

It is critical to safety that they be inflated properly and I believe that we need better methods to assure proper inflation.

Deidentified Crewmembers Analyst SSE Report 300

Overview:

Processing:

Status: Closed

ID: 300

Date/Time When Event Occurred: Wed, 07 Jan 2009 19:01 Z

Local Time When Event Occurred: 12:01

Viewer Accessible: Yes

Initial Notification Date/Time: Mon, 26 Jan 2009 18:03 Z

Submission Date/Time: Mon, 26 Jan 2009 18:03 Z

Source: Web Submission

Debrief Narrative: Findings:

Inspection by maintenance personnel found the left hand inboard tire flat.

Corrective Action:

AVN maintenance replaced the damaged wheel and tire assembly.

Additional Investigation:

A review of subject SSE and corrective action report leads the program standards office to concur with the SSE suggestion for more diligent brake application during landing.

Prepared by: Mark Whittington, AJW-34122, Ext 5353

Event: 1

Baseline Risk Assessment

Likelihood:

Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N83
Tail Number: N83
Aircraft Type: BE-300
Flight Crew Employee Information:
Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying
Narrative:
UPON LANDING, THE COPILOT, WHO WAS FLYING THE AIRPLANE, APPLIED INADVERTANT BRAKE APPLICATION CAUSING THE LEFT OUTBOARD TIRE TO FAIL. CREW WAS NOT AWARE OF FAILED TIRE UNTIL PARKING AIRCRAFT.
Phase of Flight:
Flight Phase at Start of Event: Landing
Cause
Narrative:
N/A.
Detection
How Event Detected:
Maintenance Personnel: Yes
When Event Detected:
PostFlight: Yes
Reaction
Flight Crew:
Contacted Operations: Yes
Flight Status after Event:
Flight Cancellation: Yes
Suggestions
Narrative:
MORE DILIGENT BRAKE APPLICATION DURING THE LANDING PHASE OF THE AIRCRAFT.

Deidentified Crewmembers Analyst SSE Report 287

Overview:
Processing:
Status: Closed
ID: 287
Date/Time When Event Occurred: Mon, 05 Jan 2009 20:30 Z
Local Time When Event Occurred: 14:30
Viewer Accessible: Yes
Initial Notification Date/Time: Tue, 06 Jan 2009 13:28 Z
Submission Date/Time: Tue, 06 Jan 2009 13:28 Z
Source: Web Submission
Debrief Narrative: Findings:
Inspection by maintenance personnel found the left engine fuel pump to be faulty.
Corrective Action:
AVN maintenance replaced the faulty fuel pump and performed an operational check.
Event: 1
Baseline Risk Assessment
Likelihood:
Severity:
Risk Factor:
Description
Aircraft Configuration:
Nickname: N74
Tail Number: N74
Aircraft Type: BE-300
Flight Crew Employee Information:

Primary Duties During Time of Event: Pilot Monitoring/Pilot Not Flying

Narrative:

While conducting an orbit around the DPA VOR/DME the L FUEL PRESS LO warning light illuminated. The pilot flying accomplished the memory items associated with the light and the light went out. The pilot not flying read and accomplished the appropriate checklist items. No other abnormalities were noted and the inspection continued. The crew elected to return to BTL FIFO following the inspection for maintenance.

Phase of Flight:

Flight Phase at Start of Event: Cruise

Cause

Narrative:

Maintenance found a faulty fuel pump on the left engine.

Detection

Aircraft Equipment:

Aircraft Warning/Message System: Yes

How Event Detected:

Flight Crew: Yes

When Event Detected:

In-Flight: Yes

Reaction

Flight Crew:

Contacted Company: Yes

Contacted Operations: Yes

Operated in Degraded Conditions: Yes

Flight Status after Event:

Diversion: Yes

Suggestions

Narrative:

N/A

*WARNING: The information in this document may be protected from disclosure under 49 U.S.C., section 40123 and 14 CFR part 193.
Report generated Mon, 10 Nov 2014 14:50 Z*

APPENDIX E
RESEARCHER CURRICULIM VITAE

VITA

Bradley V. Keith

Candidate for the Degree of

Doctor of Education

Thesis: QUANTITATIVE INQUIRY INTO FEDERAL AVIATION
ADMINISTRATION FLIGHT INSPECTION SERVICES SAFETY
SIGNIFICANT EVENTS

Major Field: Doctor of Education in Applied Educational Studies with the Aviation and
Space Specialization

Biographical:

Education: Graduated from Booker T. Washington High school, Tulsa, Oklahoma in May 2001; received a Bachelor's of Science degree in Aviation Management from Oklahoma State University, Stillwater, Oklahoma in May 2006; received Master of Science degree in Aviation Management from Oklahoma State University, Stillwater, Oklahoma in May 2009; completed requirements for the Doctor of Education in Applied Educational Studies in Aviation and Space from Oklahoma State University in December 2014.

Experience: Federal Aviation Administration, Flight Inspection Services, Management and Program Analyst since 2008. Prior to 2008 employed at Johnson Controls, Standard Aero, and LMI Aerospace in safety and quality management.

Professional Memberships: Standard for Business Aircraft Operations Safety Management System (IS-BAO-SMS) Accredited Auditor. Aerospace Quality Maintenance System (AS 9110) Auditor, International Organization for Standardization (ISO) 9001:2008 Certified Lead Internal Auditor. Occupational Safety and Health Administration (OSHA) Collateral Auditor.