***Occurrence Report – Helicopter and Agricultural Aviation Operators***

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| Information from reporting helps the Civil Aviation Authority (CAA) learn of current and ongoing aviation risks. Reporting gives the CAA a better understanding of what improvements will/can help keep people be and feel safe and secure within the aviation system.  Because this data is so important, the CAA has updated its forms and processes to make it easier for participants to provide this information, including the option to [report online](https://occurrencereporting.services.aviation.govt.nz/).  Occurrence reporting is required under [Civil Aviation Rule Part 12](https://www.aviation.govt.nz/rules/rule-part/part-12/). Check the information required for the occurrence is provided within this form as applicable. | |
| **Notification of an incident:** | |
| To report an accident or serious incident freephone: | 0508 ACCIDENT (0508 222 433)  This number is monitored 24 hours every day of the week. |
| To report other safety or security concerns freephone: | 0508 4SAFETY (0508 472 338)  This number is available during office hours (voice mail after hours). |
| **Filling in this form:** | |
| Before using this form consider submitting your report via the online [occurrence reporting form](https://occurrencereporting.services.aviation.govt.nz/) in the first instance.  This form has been developed in collaboration with the NZHA and NZAAA and is designed specifically for the helicopter and agricultural aviation sectors. It is designed to assist certificate holders determine the cause(s) of an occurrence. Four causal factor categories that most commonly underpin accidents and incidents in New Zealand aviation are listed below. Each category of causation should be examined against what took place. Additionally, those factors which contributed to the occurrence should be explained.  To best support the CAA and the sector improve the safety of the aviation system:   * note the steps taken to mitigate any issue in section 11, and * list in section 12 any learnings identified.   When complete, email this form as soon as possible to: [triage@caa.govt.nz](mailto:triage@caa.govt.nz?subject=Safety%20occurrence%20report). | |

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| **1. Reporter’s details** | | | | | | | |
| Name |  | | | | CAA participant no. |  | |
| Organisation |  | | | | Position |  | |
| Date |  | | Phone | |  | Email |  |
| Have you notified any other agencies? | No | Yes | | *If yes, which other agencies have you notified?* | | | |
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| **2. Occurrence details** | | | | | | | | | | | | | | | | | | | | | |
| Date of occurrence | |  | | Time | | |  | | NZST | | | NZDT | | UTC | | Location | | | |  | |
| Aircraft registration | | ZK - | | Aircraft make and model | | | | | | |  | | | | | | | | | | |
| Organisation participant no. | |  | | Organisation name | | | | | | |  | | | | | | | | | | |
| No. persons on board |  | No. of injuries: | Fatal | | | Crew | | Pax | | Serious | | | Crew | | Pax | | Minor | | | Crew | Pax |
| PIC name | |  | | | | | | | CAA participant no. / licence no. | | | | | | | | |  | | | |
| Hours last 90 days | |  | | | Hours on type | | | |  | | | | | Hours total | | | | |  | | |
| Description of occurrence (*provide an account of what took place)* | | | | | | | | | | | | | | | | | | | | | |
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| **3. Operational details** | | | | | | | | |
| Departure point |  | | Destination point |  | VFR | IFR | VMC | IMC |
| Nature of flight | | | | | | | | |
| Passenger A to A | | Passenger A to B | | Agricultural | | Other aerial work | | |
| Training dual | | Training solo | | Ferry/positioning | | Test | | |
| SAR/Air Ambulance | | Other: | | | | | | |
| Flight phase | | | | | | | | |
| Parked | | Taxi/hover taxi | | Takeoff | | Climb | | |
| Hover | | Ferry/cruise | | Circuit | | Descent | | |
| Approach | | Landing | | Other: | | | | |
| Effect on flight | | | | | | | | |
| Nil | | Aborted takeoff | | Failure to get airborne | | Emergency landing | | |
| Missed approach | | Turnback | | Abnormal landing | | Engine(s) shutdown | | |
| Avoiding action | | Loss of control/performance | | Other: | | | | |

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| **4. Type of occurrence** | | |
| Collision/strike object | Passenger/cargo related | Loss of control |
| Fuel/fluids | Component or system failure or malfunction | Engine power loss |
| External load | Airframe/equipment failure | Other: |

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| **6. Aircraft defect/engineering details** | | | | | | | | | | | | | | | | | | | | | | | | |
| Major component/system affected | | | | | | |  | | | | | | | | | | | | | | | | | |
| ATA code | | |  | | | | | | | | Part defective | | | | |  | | | | | | | | |
| Manufacturer | | |  | | | | | | | | Model | | | | |  | | | | | | | | |
| Part number | | |  | | | | | | | | Serial number | | | | |  | | | | | | | | |
| TTIS | Hours | | | Cycles | | | | TSO | | Hours | | | | Cycles | | | | TSI | | Hours | | | Cycles | |
| Detection phase | | Unscheduled | | | | | OR | | Scheduled maintenance | | | | | | Manufacturer advised | | | | | | Yes | | | No |
| Compliance with | | AD | | | | SB | | | Specify reference | | | |  | | | | | | | | | | | |
| Maintenance organisation | | | | |  | | | | | | CAA participant no. | | | | | |  | | Phone | | |  | | |
| Aircraft damage level | | | | | Destroyed | | | | Substantial | | | Minor | | | | Other: | | | | | | | | |
| Aircraft disposal | | | | | Write-off | | | | Repair | | | Unknown | | | | Other: | | | | | | | | |
| Engineering description of incident | | | | | | | | | | | | | | | | | | | | | | | | |
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| **7. Causal factor 1: Human factors –** *Factors related to human performance, decision-making, situational awareness, etc.* | | | |
| Consider the factors below and indicate if any may have contributed to the occurrence | | | |
| Decision-making | Situational awareness | Flight/mission planning | Communication |
| Operating experience | Training | Complacency | Flight discipline |
| Distraction | Other: | | |
| Explain how human factors may have contributed to the occurrence | | | |
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| **8. Causal factor 2: Mechanical/equipment factors –** *Factors related to any equipment involved, including aircraft, role equipment, ground equipment, tooling, parts, aerodrome facilities, etc.* | | |
| Consider the factors below and indicate if any may have contributed to the occurrence  *Note: if you have supplied engineering/defect information through the appropriate defect reporting form (either via the online* [*occurrence reporting form*](https://occurrencereporting.services.aviation.govt.nz/) *or using the CA005D form), this should be noted in addition to the information provided in this section* | | |
| Engine/powerplant | Airframe | Fuel/fluid systems |
| Flight controls | Instruments | Rotor systems |
| Spray gear/sling/other role equipment | Other: | |
| Explain how mechanical/equipment factors may have contributed to the occurrence | | |
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| **9. Causal factor 3: Environmental factors –** *Includes conditions that prevailed at the time of the occurrence, eg, weather, light, etc.* | | | |
| Consider the factors below and indicate if any may have contributed to the occurrence | | | |
| Wind level/direction | Turbulence | Light level | Sunstrike |
| Cloud | Rain/drizzle | Low-level hazards, eg, wires, trees, poles etc. | |
| Airstrip surface conditions | Snow/ice | Uneven terrain | |
| Other: | | | |
| Explain how environmental factors may have contributed to the occurrence | | | |
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| **10. Causal factor 4: Organisational/regulatory factors –** *Factors related to policies, procedures, aviation rules and safety culture* | | | |
| Consider the factors below and indicate if any may have contributed to the occurrence | | | |
| Operating procedures | Training policies | Maintenance procedures | Sector/industry culture |
| CAA rules and regulations | Other: | | |
| Explain how organisational/regulatory factors may have contributed to the occurrence | | | |
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| **11. Steps taken to mitigate or eliminate the identified issue(s)** |
| Describe what has been/will be done to ensure this occurrence doesn’t happen again?  *Ensure to include what steps have/will be put in place to mitigate or eliminate the above identified causal factors which may have contributed to the occurrence, and how these are intended to work long term, eg, yearly review, addition to training programme etc.* |
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| **12. Lessons learned** |
| What lessons were learnt during the process which would help future incidents?  *Include what advice could be given to other organisations to reduce their chances of a similar incident happening to them* |
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| **Email this form as an attachment to** [**triage@caa.govt.nz**](mailto:triage@caa.govt.nz) |