

## Occurrence Report - Helicopter and Agricultural Aviation

### Operators



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

PLEASE EMAIL AN ATTACHMENT OF COMPLETED FORM TO: [ca005@caa.govt.nz](mailto:ca005@caa.govt.nz)

Occurrence Date	Time	Location	Aircraft Reg ZK -
Aircraft make/model		Operator Name	Client ID
POB	Nil Injuries	Injuries Fatal	Injuries Serious
		Crew PAX	Crew PAX
			Injuries Minor
			Crew PAX

### Operational Details

Departure Point	Destination Point	VFR	IFR	VMC	IMC
<b>Nature of flight</b>	Passenger A to A	Passenger A to B	Agricultural		Other aerial work
	Training dual	Training solo	Ferry/positioning		Test
	SAR/Air ambulance	Other			
<b>Flight phase</b>	Parked	Taxi/hover taxi	Takeoff		Climb
	Hover	Ferry/cruise	Circuit		Descent
	Approach	Landing	Other		
<b>Effect on flight</b>	Nil	Aborted takeoff	Failure to get airborne		Emergency landing
	Missed approach	Turnback	Engine(s) shutdown		Loss of control/performance
	Avoiding action	Abnormal landing	Other		

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

PIC name	Licence #	Hours last 90 days	Hours on type	Hours total
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### Nature of Occurrence

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

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

Aircraft defect/Engineering details		Component/system affected		Part defective	
ATA code	Manufacturer		Model	Part no	Serial no
TTIS hours	Cycles	TSO hours	Cycles	TSI hours	Cycles
Maintenance organisation			Client ID		
Aircraft damage level	Destroyed	Substantial	Minor	Other	

### Engineering Description of Occurrence

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### Causes of the Occurrence

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

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

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

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

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

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

Other:

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

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

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Powerplant	Airframe	Rotor systems	Fuel/fluid systems
Flight controls	Instruments	Spray gear/sling/other role equipment	

Other:

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

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

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Company SOPs	Training policies	Maintenance procedures	Sector/industry culture
CAA rules & regulations	Other:		

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

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

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Submitter name

Contact number

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THANK YOU. [CLICK HERE TO SUBMIT THE FORM BY EMAIL](#)

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