

National Transportation Safety Board - Aircraft Accident/Incident Database

Accident Rpt# ERA17LA326	09/15/2017 915 CDT	Regis# N4531K	Union City, TN	Apt: N/a
Acft Mk/Mdl AIR TRACTOR INC AT 502-UNDESIGNAT	Acft SN 502-0102	Acft Dmg: SUBSTANTIAL	Rpt Status: Prelim	Prob Caus: Pending
	Acft TT 5490	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 137	
Opr Name: LONDE AIR LLC	Opr dba:	Aircraft Fire: NONE		AW Cert: SPR

Events

1. Enroute-cruise - Loss of engine power (total)
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Narrative

On September 15, 2017, about 0915 central daylight time, an Air Tractor AT-502, N4531K, was substantially damaged during collision with terrain following a forced landing after a total loss of engine power while in cruise flight near Union City, Tennessee. The commercial pilot was not injured. Visual meteorological conditions prevailed, and no flight plan was filed for the aerial application flight which was conducted under the provisions of 14 Code of Federal Regulations Part 137.

In an interview with a Federal Aviation Administration (FAA) inspector, the pilot reported he was in cruise flight on his way to an application site when he heard a 'pop' and the engine stopped producing power. The pilot maneuvered the airplane for a forced landing on a roadway, but had to amend his forced landing site to a cornfield adjacent to the road due to vehicle traffic. After touchdown, the main landing gear separated which resulted in substantial damage to the fuselage.

The pilot held a commercial pilot certificate with a rating for airplane single-engine land. The pilot reported 18,000 total hours of flight experience, of which 3,034 hours were in the accident airplane make and model.

According to FAA records, the airplane was manufactured in 1990 and had accrued 5,490 total aircraft hours.

At 0915, the weather recorded at Everett-Stewart Regional Airport (UCY), about 6 miles east of the accident site, included clear skies and wind from 160ø at 4 knots. The temperature was 23øC, and the dew point was 20øC. The altimeter setting was 30.06 inches of mercury.

The wreckage was recovered from the accident site, and will be examined at a later date.

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Accident Rpt# ANC17CA041 08/03/2017 1300 AKS Regis# N351SH Delta Junction, AK Apt: N/a
Acft Mk/Mdl AIRBUS AS350-B3 Acft SN 4598 Acft Dmg: SUBSTANTIAL Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl SAFRAN HELICOPTER ENGINES ARRIEL Acft TT 3824 Fatal 0 Ser Inj 0 Flt Conducted Under: FAR 135
Opr Name: SOLOY HELICOPTERS, LLC Opr dba: SOLOY HELICOPTERS, LLC Aircraft Fire: NONE
AW Cert: STN

Summary

The helicopter pilot reported that he was transporting a passenger to a remote drilling site where a tracked drilling unit was stationed. He reported that he landed into the wind, which necessitated descending over bordering trees into the drilling site. The helicopter touched down on the dirt, and upon lowering the collective, he reported that he heard a "bang," and the helicopter slowly started to "pick up a ground wobble." The pilot shut down the helicopter, and both occupants exited without further incident.

A postaccident inspection revealed that the blue and red main rotor blades sustained substantial damage from impacting a black 1.5-inch steel frame attached to the tracked drilling unit, which is used to mount a canvas weather shelter for the drilling crews. The pilot reported that the steel frame was not visible to him from above as he was descending into the drilling site. The pilot further reported that he had made multiple landings at the drilling site in the past 3 months and that, with the previous landings, he had landed farther past the tracked drilling unit, and the steel frame was always behind the helicopter.

The pilot reported that there were no preimpact mechanical failures or malfunctions with the airframe or engine that would have precluded normal operation. The Federal Aviation Administration Helicopter Flying Handbook (FAA-H-8083-21A, 2012) discusses high and low reconnaissance procedures and states, in part:

The purpose of conducting a high reconnaissance is to determine direction and speed of the wind, a touchdown point, suitability of the landing area, approach and departure axes, and obstacles for both the approach and departure.

A low reconnaissance is accomplished during the approach to the landing area. When flying the approach, verify what was observed in the high reconnaissance, and check for anything new that may have been missed at a higher altitude, such as wires and their supporting structures (poles, towers, etc.), slopes, and small crevices.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's failure to maintain clearance from a steel frame attached to a tracked drilling unit. Contributing to the accident was the pilot's failure to visually identify the steel frame during the reconnaissance process.

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Events

1. Landing - Miscellaneous/other
2. Landing - Collision during takeoff/land
3. Landing - Collision with terr/obj (non-CFIT)

Findings - Cause/Factor

1. Personnel issues-Psychological-Attention/monitoring-Monitoring environment-Pilot - C
2. Environmental issues-Physical environment-Object/animal/substance-Ground equipment-Effect on operation - C

Narrative

The helicopter pilot reported that he was transporting a passenger to a remote drilling site, where a tracked drilling unit was stationed. He reported that he landed into the wind, which necessitated descending over bordering trees into the drilling site. The helicopter touched down on the dirt, and upon lowering the collective, he reported he heard a "bang" and the helicopter slowly started to "pick up a ground wobble." The pilot shutdown the helicopter and both occupants exited without further incident.

A postaccident inspection revealed that the blue and red main rotor blades sustained substantial damage from impacting a black 1.5-inch steel frame attached to the tracked drilling unit, which is used to mount a canvas weather shelter for the drilling crews. The pilot reported that the steel frame was not visible to him from above as he was descending into the drilling site. The pilot further reported that multiple landings have been made to the drilling site in the past 3 months, and that with the previous landings he landed further past the tracked drilling unit and the steel frame was always behind the helicopter.

The pilot reported that there were no preimpact mechanical failures or malfunctions with the airframe or engine that would have precluded normal operation.

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A low reconnaissance is accomplished during the approach to the landing area. When flying the approach, verify what was observed in the high reconnaissance, and check for anything new that may have been missed at a higher altitude, such as wires and their supporting structures (poles, towers, etc.), slopes, and small crevices.

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Accident Rpt# GAA17CA244	04/24/2017 1225 CDT	Regis# N899CZ	Waukesha, WI	Apt: Waukesha County UES
Acft Mk/Mdl BEECH 99-A		Acft SN U-96	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl PRATT & WHITNEY PT6A-28		Acft TT 30823	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: FREIGHT RUNNERS EXPRESS INC		Opr dba:		Aircraft Fire: NONE
				AW Cert: STN

Events

1. Enroute - Birdstrike

Narrative

The pilot in command (PIC) of the airplane reported that during an instrument flight rules instructional flight, the airplane was established on a very high frequency omnidirectional range approach. The PIC reported that during the approach he observed a large bird that dove into the nose section of the airplane. The PIC recalled that there wasn't any reaction time between the initial observation and impact. He terminated the training flight and landed the airplane as soon as practical and without further incident. The airplane sustained substantial damage to the fuselage frame.

The pilot reported that there were no preaccident mechanical malfunctions or failures with the airplane that would have precluded normal operation.

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Accident Rpt# GAA17CA218	04/06/2017 1035 PDT	Regis# N206SA	La Verne, CA	Apt: Brackett Field POC
Acft Mk/Mdl BELL 206-B		Acft SN 1013	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl ROLLS ROYCE 250-C20		Acft TT 8482	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: HAVASU HELI FLIGHTS, LLC		Opr dba:		Aircraft Fire: NONE
				AW Cert: STN

Events

3. Autorotation - Hard landing

Narrative

The flight instructor in the helicopter reported that he was providing hovering autorotation training to a private pilot. The flight instructor reported that he rolled off the throttle to initiate the maneuver and the private pilot, "raised the collective too soon which resulted in the aircraft climbing." The rotor inertia decayed and a main rotor blade struck the tailboom after the helicopter struck the ground. The helicopter sustained substantial damage to the tail rotor drive shaft.

The pilot reported that there were no preaccident mechanical malfunctions or failures with the helicopter that would have precluded normal operation.

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Accident Rpt# ERA15LA374	09/20/2015 1900 EDT	Regis# N165BH	Thomaston, GA	Apt: N/a
Acft Mk/Mdl BELL 206-L1		Acft SN 45249	Acft Dmg: DESTROYED	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl ALLISON 250-C28 SER		Acft TT 7977	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 137
Opr Name: DAH AIRCRAFT		Opr dba:		Aircraft Fire: NONE
				AW Cert: STN

Events

1. Landing - Flight control sys malf/fail
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Narrative

On September 20, 2015, about 1900 eastern daylight time, a Bell 206L-1, N165BH, was destroyed during a collision with a ground vehicle and terrain following a flight control malfunction and subsequent loss of control near Thomaston, Georgia. The commercial pilot was not injured. Visual meteorological conditions prevailed, and no flight plan was filed for the local aerial application flight, which was conducted under the provisions of 14 Code of Federal Regulations Part 137.

In a telephone interview, the pilot said that the accident occurred at a job site. The purpose of the flight was to establish spray patterns and flow rates and to have the GPS and spray equipment calibrated for the contracted job. He said that he departed from the platform-equipped "mix" truck about 10 minutes before the accident and returned to land on the truck to clean the windshield of the helicopter.

The pilot said that he performed a right pedal turn to land on the truck, and, just before touchdown, a pin that connected a push-pull tube to the left anti-torque pedal broke resulting in a loss of directional control. The pilot maneuvered the helicopter away from the truck to avoid striking his employees and then tried unsuccessfully to land back on the truck's platform. He repositioned away from the truck, closed the throttle, and lowered the collective to land, and the main rotor blades struck the side of the truck.

The pilot held a commercial pilot certificate with ratings for airplane multi-engine land and rotorcraft/helicopter. His most recent second-class Federal Aviation Administration medical certificate was issued on July 2, 2015. The pilot reported 11,409 total hours of flight experience of which 40 hours were in the accident helicopter make and model.

The helicopter was manufactured in 1979, and at the time of the accident it had been operated for about 16 hours since its most recent annual inspection was completed on September 7, 2015, at 7,977.2 total aircraft hours. The helicopter was equipped with a left-hand "command" kit, and the pilot was flying it from the left seat at the time of the accident.

In addition, the helicopter was equipped with a tail rotor pedal lockout kit, which was designed to disconnect and lockout the tail rotor pedals at the copilot's seat to prevent passenger interference. For this make and model helicopter, the left seat would typically be the copilot's seat; however, as the accident helicopter was equipped with a left-hand command kit, the right seat was the copilot's seat. The kit, which was manufactured by Aeronautical Accessories and installed in accordance with supplemental type certificate SR00513AT, could be in either "Lockout" mode to prevent use of the pedals or "Engaged" mode for pedal control.

Examination of photographs provided by the operator revealed that the main transmission and the engine were torn from their mounts, and the aft fuselage was destroyed. The tail boom was separated just aft of its mount. Photographs of the tail rotor pedal assembly revealed that the left expandable pin, which was a part included in the tail rotor pedal lockout kit, had fractured and disconnected from the left anti-torque pedal to the tail rotor control system. The expandable pin connecting the right pedal to the tail rotor control system remained intact and engaged.

The operator shipped the pin by commercial carrier to the NTSB Eastern Region Headquarters in Ashburn, Virginia, for further examination as requested, but mislabeled the package with the wrong street address. The carrier shipped the package to a delivery center in Vienna, Virginia, and then redirected the package to a delivery center in San Francisco, California, where it was lost. Consequently, fracture analysis on the fractured pin could not be performed. Photographs of the fracture were not of sufficient quality to perform a visual fracture analysis.

The pilot/operator suggested that the accident could have been prevented if the lockout kit were not authorized for use concurrent with the left-hand command kit.

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A review of the design and materials of the expandable pin by the FAA Aircraft Certification Office responsible for the kit and the kit manufacturer revealed that the pins were designed to replace the "original bolts and are stressed as such." The kit's instructions for continued airworthiness mandated both daily and 300-hour interval inspections for condition and security of the pins.

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Accident Rpt# CEN17FA355	09/16/2017 1630	Regis# N213TV	Ancho, NM	Apt: N/a
Acft Mk/Mdl BELL 206L 3-L3		Acft SN 51298	Acft Dmg: SUBSTANTIAL	Rpt Status: Prelim Prob Caus: Pending
Eng Mk/Mdl ALLISON 250-C30 SER			Fatal 1 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: WQRE NEWS 13		Opr dba:		Aircraft Fire: GRD
				AW Cert: STN

Events

1. Enroute - Controlled flight into terr/obj (CFIT)

Narrative

On September 16, 2017 about 1630 mountain daylight time, a Bell 206L-3 helicopter N213TV, impacted terrain near Ancho, New Mexico. The commercial rated pilot was fatally injured and the helicopter was destroyed. The helicopter was registered to LIN Television Corporation, Providence, Rhode Island, and operated by WQRE, TV 13, Albuquerque, New Mexico, under the provisions of 14 Code of Federal Regulations Part 91 as a business flight. Visual meteorological conditions prevailed.

The initial report indicated that the pilot had flown to the Carlsbad area, to conduct a news story. The pilot spent the night there and was on the return flight. A person, located near a cattle ranch, saw smoke and drove over to investigate. The person then notified authorities of the crash.

The on-site examination of the wreckage revealed the helicopter impacted in open ranch land. Ground scars and signatures were consistent with a slight nose low impact with terrain, with wreckage spread along path, several hundred feet in length. All major components were located at the wreckage site. A post-crash fire consumed the major of the main cabin wreckage.

After the initial on-site documentation of the wreckage, the helicopter was recovered to a secure facility, for further examination.

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Accident Rpt# GAA17CA404	07/11/2017 1510 PDT	Regis# N357PJ	King Vale, CA	Apt: N/a
Acft Mk/Mdl EUROCOPTER AS 350-B3		Acft SN 3608	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual Prob Caus: Pending
Eng Mk/Mdl SAFRAN (TURBOMECA) 2B		Acft TT 1937	Fatal 0 Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: PJ HELICOPTERS, INC		Opr dba:		Aircraft Fire: GRD
				AW Cert: STN

Summary

The pilot of the helicopter reported that, during the landing on the unimproved dirt parking lot, dust started to kick up, and he transitioned to looking through the "chin bubble" for a visual point of reference. When the helicopter was about 5 to 6 ft above the ground, the pilot felt a sudden impact, followed by subsequent impacts from the two additional rotor blades impacting what was later found to be a tree. The helicopter "violently" fell to the ground and rolled onto its left side. The helicopter sustained substantial damage to the fuselage and main rotor system.

The pilot reported that there were no preaccident mechanical failures or malfunctions with the helicopter that would have precluded normal operation.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's failure to maintain clearance from trees while landing in a dusty, unimproved landing zone.

Events

1. Landing - Collision with terr/obj (non-CFIT)
2. Landing - Loss of control in flight
3. Landing - Roll over

Findings - Cause/Factor

1. Personnel issues-Psychological-Attention/monitoring-Monitoring environment-Pilot - C
2. Aircraft-Aircraft oper/perf/capability-Performance/control parameters-Altitude-Not attained/maintained - C
3. Environmental issues-Physical environment-Object/animal/substance-Tree(s)-Effect on operation - C
4. Environmental issues-Conditions/weather/phenomena-Ceiling/visibility/precip-Obscuration-Effect on personnel

Narrative

The pilot of the helicopter reported that, during the landing on the unimproved dirt parking lot, dust started to kick up, and he transitioned to looking through the "chin bubble" for a visual point of reference. When the helicopter was about 5 to 6ft. above the ground, the pilot felt a sudden impact, followed by subsequent impacts from the two additional rotor blades impacting what later was found to be a tree. The helicopter "violently" fell to the ground and rolled onto its left side.

The helicopter sustained substantial damage to the fuselage and main rotor system.

The pilot reported that there were no preaccident mechanical failures or malfunctions with the helicopter that would have precluded normal operation.

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Accident Rpt# GAA17CA146	03/12/2017 1700 PDT	Regis# N675TH	Julian, CA	Apt: N/a
Acft Mk/Mdl KAMAN AEROSPACE CORP K 1200-NO	Acft SN A94-0025	Acft Dmg: SUBSTANTIAL	Rpt Status: Factual	Prob Caus: Pending
Eng Mk/Mdl HONEYWELL T5317-A1	Acft TT 9821	Fatal 0	Ser Inj 0	Flt Conducted Under: FAR 091
Opr Name: TIMBERLINE HELICOPTERS INC	Opr dba:	Aircraft Fire: NONE		

Summary

The pilot of the helicopter reported that he had landed and was going to reposition to another company landing zone after dropping off his crew chief. The pilot opened the engine cowling to allow the engine to cool before restart. However, the pilot did not perform a thru-flight walkaround inspection and climbed into the cockpit and took off. About 60 seconds after departure, he felt a large thump throughout the airframe and then landed as soon as practicable. Upon shutdown and inspection, he noticed that the engine cowling had departed the helicopter and struck the right two main rotor blades and the vertical stabilizer, which resulted in substantial damage.

The pilot reported that there were no preaccident mechanical malfunctions or failures with the helicopter that would have precluded normal operation.

In the recommendations section of the National Transportation Safety Board Pilot Aircraft Accident Report, the pilot specified that the company has issued a policy that prohibits opening the engine cowling for the sole purpose of allowing the engine to cool. Additionally, the policy directed a pretakeoff helicopter inspection to be completed by a qualified technician.

Cause Narrative

THE NATIONAL TRANSPORTATION SAFETY BOARD DETERMINED THAT THE CAUSE OF THIS OCCURRENCE WAS: The pilot's failure to conduct a thru-flight walkaround inspection, which resulted in the engine cowling remaining open and subsequently separating from the helicopter and striking the main rotor blades and vertical stabilizer during departure.

Events

1. Takeoff - Part(s) separation from AC

Findings - Cause/Factor

1. Personnel issues-Action/decision-Action-Forgotten action/omission-Pilot - C
2. Personnel issues-Task performance-Inspection-Preflight inspection-Pilot - C

Narrative

The pilot of the helicopter reported that he had landed and was going to reposition to another company landing zone after dropping of his crew chief. The pilot opened the engine cowling to allow the engine to cool before restart. However, the pilot did not perform a thru flight walk around and climbed in to the cockpit and took off. About sixty seconds after departure, he felt a large thump throughout the airframe and landed as soon as practicable. Upon shutdown and inspection, he noticed that the engine cowling had departed the helicopter and struck the right two main rotor blades and the vertical stabilizer. Substantial damage was sustained to the right main rotor blades and the vertical stabilizer.

The pilot reported that there were no preaccident mechanical malfunctions or failures with the airplane that would have precluded normal operation.

In the recommendations section of the National Transportation Safety Board Pilot Aircraft Accident Report, the pilot specified that the company has issued a policy that prohibits opening the engine cowling for the sole purpose of allowing the engine to cool. Additionally, the policy directed a pre-takeoff helicopter inspection to be completed by a qualified technician.