Safety Regulation Group Safety Investigation and Data Department



Follow-up Action on Occurrence Report

ACCIDENT TO CESSNA U206F, G-BAGV, AT STRATHALLAN AIRFIELD ON 5 MAY 2002
(AIRCRAFT CRASHED ON APPROACH TO LANDING)

CAA FACTOR NUMBER : F16/2003

FACTOR PUBLICATION DATE : 11 July 2003

OPERATOR : Parachute Club

CAA OCCURRENCE NUMBER : 2002/02787

AAIB REPORT : Bulletin 6/2003

SYNOPSIS

(From AAIB Report)

The aircraft was operated by a parachuting club and was on its twelfth sortie of the day at about 1955 hrs (2055 hrs local time) operating on grass Runway 10. The visibility was good, with no cloud and only light winds. The aircraft was being flown by the Chief Pilot, who was also the Chairman of the club; it was his twelfth sortie that day and his eighth in G-BAGV. The accident was observed by a number of club members who were around the club buildings and hangar, abeam the threshold of the runway in use.

The pilot reported that the aircraft had behaved normally during a drop of parachutists from 4,500 feet altitude and the subsequent 'straight in' approach to landing. However, just as the aircraft crossed the airfield boundary, with full flap and "at about 70 mph, the nose dropped. The aircraft struck the ground nose-down and turned over. The pilot recalled hearing a bang just prior to the loss of control and also that he had trimmed the elevator control all the way back but was still holding a small amount of back pressure on the controls. The aircraft came to rest, inverted, some 75 metres inside the airfield boundary. The pilot sustained minor head injuries but, although he was upside down, he was able to escape from the aircraft through the cargo door with the assistance of the airfield staff. There was no fire.

A number of the eyewitnesses wrote down brief accounts of what they had observed during the accident. The accounts agreed in stating that the landing approach had appeared normal and a number commented that, at a late stage (one suggested 12 feet wheel height and the engine noise reducing at the same moment), the nose had dropped and the rate of descent increased. The accounts were consistent in describing the nose leg collapsing as the aircraft struck the ground and the aircraft tipping over its nose onto its back.

FOLLOW UP ACTION

The one Safety Recommendation, made by the AAIB following their investigation, is reproduced below, together with the CAA's response.

Recommendation 2003-26

The Civil Aviation Authority should re-iterate its advice regarding the use and re-use of self-locking fasteners, contained in Leaflet 2-5 of CAP 562, in a document likely to be widely read by and easily accessible to aircraft maintenance engineers and technicians.

CAA Response

The CAA accepts this Recommendation.

The advice contained in Civil Aircraft Airworthiness Inspection & Procedures (CAP 562) Leaflet 2-5 has been included in Airworthiness Notices (CAP 455) Notice 12 "Experience from Incidents" Appendix 17, Self-locking fasteners. Airworthiness Notices are circulated to every CAA licensed aircraft maintenance engineer and every CAA approved maintenance organisation. CAP 455 is also available free from the CAA Internet web site www.caa.co.uk.

The CAA will re-iterate its advice regarding the use and re-use of self locking fasteners contained in CAP 562 and CAP 455 to the light aircraft industry, with an article in the September 2003 issue of the General Aviation Safety Information Leaflet (GASIL). This document is widely read by, and easily accessible to, aircraft maintenance engineers and technicians associated with the light aircraft industry.

CAA Status - Open