Corporate Communications
External Information Services

6 August 2014
FOIA reference: F0002014

Dear XXXX

I am writing in respect of your recent request dated 26 July 2014, for the release of information held by the Civil Aviation Authority (CAA).

Your request:

> *1. All official 'near misses' involving civil aircraft both arriving and leaving at Heathrow from 1st January 2004 to July 25th 2014*
>
> *2.. Any incidents relating to permanent or temporary technical failure while airborne on both take-off and approach for landing, which could have potentially endangered life from 1st January 2004 to July 25th 2014. This would include engine failure, landing gear failure, structural integrity etc.*

Our response:

Having considered your request in line with the provisions of the Freedom of Information Act 2000 (FOIA), we are pleased to be able to provide the information below.

Incident reports are provided to the CAA under the terms of the Mandatory Occurrence Reporting (MOR) scheme, as described under Article 226 of the Air Navigation Order 2009 (ANO).

Each report made is reviewed and, where appropriate, further investigation carried out and action taken.

1. We have searched the UK CAA database for all occurrences that have involved an Airprox (official 'near miss' subject to a review by the UK Airprox Board) inside UK controlled airspace during the period 1 January 2004 to all processed reports as at 25 July 2014 for an aircraft (regardless of nationality) which has either departed London Heathrow or was en route to London Heathrow and provided the information in attachment one.

The UK Airprox Board (UKAB) separately collects reports of Airprox incidents and produces a regular review of assessed Airprox incidents, which can be found at http://www.airproxboard.org.uk).

Details of completed investigations can be found through the following links:

http://www.airproxboard.org.uk/default.aspx?catid=423&pagetype=90&pageid=5638

http://www.airproxboard.org.uk/default.aspx?catid=423&pagetype=68&gid=430

2. In order to provide data relating to general structural integrity or significant engine failures we have also searched the CAA database for any incident which has been classified as either an accident or a serious incident where the primary error has been assessed as a technical malfunction whilst the aircraft (regardless of nationality) is airborne either during take-off or approach for landing between the dates 1 January 2004 to all processed reports as at 25 July 2014 and provided a summary of those reports (see attachment two). We have, however, removed identifying information from these reports as this information is exempt from disclosure under Section 44 (1) (a) of the FOIA.

   Section 44 (1) (a) of the FOIA provides that information is exempt information if its disclosure is prohibited by, or under, any enactment. Under Section 23 of the Civil Aviation Act 1982, information which relates to a particular person (which includes a company or organisation) and has been supplied to the CAA pursuant to an ANO is prohibited from disclosure (a copy of this exemption can be found below).

   For more information about the Mandatory Occurrence Reporting scheme, please refer to CAP382 which can be found at www.caa.co.uk/cap382.

If you are not satisfied with how we have dealt with your request in the first instance you should approach the CAA in writing at:-

Mark Stevens
External Response Manager
Civil Aviation Authority
Aviation House
Gatwick Airport South
West Sussex
RH6 0YR

mark.stevens@caa.co.uk

The CAA has a formal internal review process for dealing with appeals or complaints in connection with Freedom of Information requests. The key steps in this process are set in the attachment.

Should you remain dissatisfied with the outcome you have a right under Section 50 of the Freedom of Information Act to appeal against the decision by contacting the Information Commissioner at:-

Information Commissioner's Office
FOI/EIR Complaints Resolution
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
www.ico.gov.uk/complaints.aspx

Should you wish to make further Freedom of Information requests, please use the e-form at http://www.caa.co.uk/foi.

Yours sincerely

Rick Chatfield
Information Rights and Enquiries Officer

CAA INTERNAL REVIEW & COMPLAINTS PROCEDURE

- The original case to which the appeal or complaint relates is identified and the case file is made available;
- The appeal or complaint is allocated to an Appeal Manager, the appeal is acknowledged and the details of the Appeal Manager are provided to the applicant;
- The Appeal Manager reviews the case to understand the nature of the appeal or complaint, reviews the actions and decisions taken in connection with the original case and takes account of any new information that may have been received. This will typically require contact with those persons involved in the original case and consultation with the CAA Legal Department;
- The Appeal Manager concludes the review and, after consultation with those involved with the case, and with the CAA Legal Department, agrees on the course of action to be taken;
- The Appeal Manager prepares the necessary response and collates any information to be provided to the applicant;
- The response and any necessary information is sent to the applicant, together with information about further rights of appeal to the Information Commissioners Office, including full contact details.

Freedom of Information Act: Section 44

(1) Information is exempt information if its disclosure (otherwise than under this Act) by the public authority holding it-

(a) is prohibited by or under any enactment,
(b) is incompatible with any Community obligation, or
(c) would constitute or be punishable as a contempt of court.

(2) The duty to confirm or deny does not arise if the confirmation or denial that would have to be given to comply with section 1(1)(a) would (apart from this Act) fall within any of paragraphs (a) to (c) of subsection (1).

File number	UTC date	Occurrence class	Make/mdl/srs [Make]	Flight phase	Phase of Flight	Headline
200401531	14/03/2004	Accident	AGUSTA	Take-off	Initial climb	Heavy landing due to tail rotor driveshaft failure. Substantial damage. No injury to 2 POB. AAIB Field investigation.
200400018	05/01/2004	Accident	PIPER	Take-off	Initial climb	Engine failure after take off. Aircraft damaged during forced landing. No injury to 1 POB. AAIB AARF investigation.

200400101	06/01/2004	Serious incident	ENSTROM	Take-off	Initial climb	Low Frequency (LF) vibration felt at 1000ft. Aircraft returned. Nr4 tail rotor driveshaft bearing failed. AAIB Field investigation.
200400166	09/01/2004	Accident	BAE	Landing	Landing	AAIB Initial Notification : NLG failed to deploy. Aircraft landed with nose supported by the open NLG doors. Passengers evacuated.
200401579	14/03/2004	Serious incident	BAE	Take-off	Take-off	Unable to lock flight deck door. Door hinge bracket failed.
200402145	07/04/2004	Accident	RAYTHEON	Landing	Landing	Aircraft departed runway on landing, struck a number of obstacles and was destroyed. No injury to 1 POB. AAIB Fieldinvestigation.

200402195	12/04/2004	Accident	DIAMOND	Take-off	Initial climb	Engine ran roughly and produced smoke during climb out from touch and go. Aircraft relanded but departed runway, damaging landing gear. No injury to 1 POB. AAIB AARF investigation.
200402268	13/04/2004	Accident	FOURNIER	Landing		Main wheel failed to fully extend and collapsed on landing. Substantial damage. No injury to 1 POB. AAIB AARF investigation.
200402981	13/05/2004	Accident	OTHER	Landing	Landing	AAIB Initial Notification: Skyranger 582(1) microlight NLG collapsed during precautionary landing due to rough running engine. Substantial damage. No injuries to 2 POB. Subject to BMAA investigation.
200403006	13/05/2004	Accident	OTHER	Take-off	Initial climb	AAIB Initial Notification: Thruster T300 microlight made heavy landing following engine failure after take-off. Tail separated. No injury to 1 POB. Subject to BMAA investigation.

200400362	21/01/2004	Accident	PIPER	Landing	Landing	RH MLG collapsed during landing run. Substantial damage. No injuries to 3 POB. AAIB AARF investigation.
200400563	30/01/2004	Accident	PIPER	Landing	Landing	NLG collapsed on landing. No injury to 1 POB. AAIB AARF investigation.

200403842	14/06/2004	Accident	AVID	Take-off	Initial climb	Engine stopped during climb. Aircraft crashed and lodged in tree on approach to field for forced landing. Minor injury to 1 POB. AAIB AARF investigation.
200403873	15/06/2004	Accident	CESSNA	Landing	Landing	LH MLG collapsed during landing roll. Substantial damage.No injury to 2 POB. AAIB AARF investigation.
200404037	22/06/2004	Accident	PIPER	Landing	Landing	Landing gear collapsed on landing. No injury to 1 POB. AAIB AARF investigation.

200404169	27/06/2004	Accident	CESSNA	Take-off	Initial climb	Engine lost power in climb. During attempted forced landing aircraft struck trees and crashed. Aircraft destroyed. 6 POB - 4 fatalities, 2 serious injuries. AAIB Field investigation.
200404189	27/06/2004	Accident	OTHER	Take-off	Initial climb	X'AIR V2(2) microlight inverted during forced landing following engine failure on climb out. Substantial damage. Noinjuries to 2 POB. AAIB AARF investigation.
200404211	29/06/2004	Accident	PIPER	Landing	Landing	Unable to obtain three greens. Aircraft had to land with NLG not fully locked down. Damage to NLG and propeller. Noinjury to 1 POB. AAIB AARF investigation.

200400683	29/01/2004	Accident	BAE	Landing	Landing	AAIB Initial Notification: Nose landing gear failed to extend. Structural damage to nose and both propellers. Subject to NTSB investigation.
200400741	09/02/2004	Accident	DASSAULT	Landing	Landing	RH MLG partially retracted and aircraft departed runway on landing following diversion due to hydraulic failure. Substantial damage. No injuries to 4 POB. AAIB Field investigation.
200400766	09/02/2004	Accident	CESSNA	Landing	Landing	NLG collapsed on landing. Substantial damage. No injury to 1 POB. AAIB Field investigation.

200400907	16/02/2004	Accident	CESSNA	Landing	Landing	Engine lost power. Aircraft returned and overran on landing. Substantial damage. No injury to 2 POB. AAIB AARF investigation.
200401025	21/02/2004	Accident	BOEING	Landing	Landing	LH MLG shimmy on landing, leading to failure of associated torsion link. No injury to 120 POB. AAIB Field investigation.
200405678	16/08/2004	Accident	SOCATA	Landing	Landing	NLG failed to retract and collapsed on landing when the aircraft returned. Substantial damage. No injuries to 2 POB. AAIB AARF investigation.

200405770	14/08/2004	Accident	RUTAN	Landing	Landing	Nosewheel detached and bounced up into the propeller during landing. No injuries to 1 POB. AAIB AARF investigation.
200405885	23/08/2004	Accident	AIRBUS	Landing	Landing	Severe NLG vibration during taxi after landing due to nosewheel castoring/landing gear torsion link failure. No injuries to 128 POB. Subject to French BEA investigation.
200405898	24/08/2004	Serious incident	BOEING	Take-off	Take-off	Serious Incident: LH engine failure on take off. Aircraftreturned and landed safely. Engine intake acoustic liningmissing. Subject to investigation by Australian authority.
200404624	13/07/2004	Accident	OTHER	Take-off	Initial climb	AAIB Initial Notification: Engine failure on take off. Substantial damage. No reported injury. Subject to BMAA investigation.
200406199	02/09/2004	Accident	OTHER	Take-off	Take-off	AAIB Initial Notification: Military accident - Engine surge during circuit training. All 3 occupants ejected - 2 fatalities, 1 serious injury. Subject to Military Board of Inquiry.
200406200	03/09/2004	Accident	PIPER	Take-off	Take-off	LH MLG wheel separated on take off following failure of lower torque link pivot bolt. Aircraft damaged during subsequent landing. No injuries to 2 POB. AAIB AARF investigation.

200406236	01/09/2004	Accident	BOEING	Take-off	Take-off	Tyre burst on take off followed by loss of 'A' hydraulic system. Aircraft returned and landed safely after burning off fuel. No injury to 143 POB. AAIB AARF investigation.
200406433	08/09/2004	Serious incident	FOKKER	Take-off	Take-off	Take off rejected due to failure of aircraft to maintain runway centreline and suspected LH engine fire. AAIB Fieldinvestigation.

200406887	23/09/2004	Accident	AVIONS ROBIN	Approach	Approach	Engine lost power on final approach. Aircraft landed heavily short of runway and struck hedge. Substantial damage. No injury to 1 POB. AAIB AARF investigation.
200407447	16/10/2004	Accident	MOONEY	Take-off	Initial climb	MAYDAY declared due to engine power loss. A/c stalled during attempted return and nose dived into ground from 300ft. A/c destroyed, 1 POB fatal. AAIB Field investigation.

200407449	15/10/2004	Accident	GRUMMAN	Take-off	Initial climb	UK Reportable Accident: Engine failure after take-off. Forced landing in field. NLG collapsed. No injury to 3 POB. AAIB AARF investigation.
200407690	24/10/2004	Accident	ENSTROM	Take-off	Initial climb	Helicopter ditched in sea following loss of engine power.Helicopter destroyed. Three POB - one fatality. Norwegianauthority investigation.

200404866	18/07/2004	Accident	BOEING	Landing	Landing	Brakes locked during landing roll and aircraft overturned. Substantial damage. No injury to 2 POB. AAIB AARF investigation.
200407876	30/10/2004	Accident	YAKOVLEV	Landing	Landing	Difficulties experienced in extending landing gear which subsequently folded on landing. No injury to 1 POB. AAIB AARF investigation.

200408076	04/11/2004	Serious incident	WESTLAND	Approach	Approach	Engine cowling separated during approach. Rotor blades damaged. AAIB Field investigation.
200408682	30/11/2004	Accident	PIPER	Landing	Landing	Landing gear collapsed on landing. Substantial damage. Noinjury to 1 POB. AAIB AARF investigation.
200408730	01/12/2004	Accident	SOCATA	Landing	Landing	On landing gear extension, only one green was obtained. Flypast showed all gear down but RH MLG collapsed on landing. No injury to 2 POB. AAIB AARF investigation.

200408902	09/12/2004	Accident	EUROPA	Landing	Landing	Aircraft bounced and overshot runway on landing followingdiversion due to rough running engine. Substantial damage. Minor injuries to 2 POB. AAIB AARF investigation.
200409293	21/12/2004	Serious incident	DE HAVILLAND	Take-off	Take-off	High control forces in pitch during rotation. Frozen elevator spring tabs suspected due to either incomplete de-icing or rehydration of de-icing fluid residue. AAIB AARF investigation.
200405542	11/08/2004	Serious incident	BOEING	Take-off	Take-off	Serious Incident: High engine vibration on take off. Smoke in cabin. Aircraft returned. Crew and passengers evacuated. Internal engine fire/damage. NTSB investigation.

200405605	15/08/2004	Accident	OTHER	Landing	Landing	Puma Sprint microlight's nosewheel assembly detached during landing. Substantial damage. Serious injuries to 2 POB.AAIB Field investigation.
200405636	14/08/2004	Serious incident	FOKKER	Landing	Landing	NLG unsafe indication. Checklist actioned to no effect. Aircraft landed normally with unsafe indication clearing after touchdown. AAIB Field investigation.
200501357	27/02/2005	Accident	OTHER	Take-off	Initial climb	Engine began to run roughly then stopped. Landing gear collapsed during forced landing. No injury to 1 POB. AAIB AARF investigation.

200501421	01/03/2005	Accident	BOEING	Landing	Landing	UK Reportable Accident: LH MLG fire after landing. Emergency evacuation carried out. AAIB Field investigation.
200501700	28/02/2005	Serious incident	SHORT	Landing	Landing	Nose landing gear collapsed during landing.
200501701	10/03/2005	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Thruster T600N microlight engine failed on take off. Forced landing in field. Substantial damage. No injury to 2 POB. Subject to BMAA investigation.
200502010	22/03/2005	Accident	FOKKER	Landing	Landing	LH MLG torque link centre bolt failed during turn to backtrack runway. Damage to LH MLG, wheels and brakes. No injury to two POB. AAIB AARF investigation.

200502455	29/03/2005	Accident	EMBRAER	Take-off	Take-off	UK Reportable Accident: Rejected take off due to tyre burst. Subject to Swiss authority investigation.
200502684	06/04/2005	Accident	BRITTEN NORMAN	Landing	Landing	Foreign Accident: Aircraft veered off runway and struck drainage ditch due to failure of LH MLG oleo attachment bracket. Substantial damage. No injuries to 3 POB. Subject toNTSB investigation.
200503054	26/04/2005	Accident	STODDARD HAMILTON	Take-off	Initial climb	Aircraft returned due to landing gear indication anomaly.NLG collapsed on landing. Substantial damage. No injury to 1 POB. AAIB AARF investigation.

200500371	19/01/2005	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Engine failure after take off. Aircraft crashed in field close to runway. Substantial damage. No injury to 2 POB. AAIB AARF investigation.
200503628	18/05/2005	Serious incident	AIRBUS	Landing	Landing	A/c steered to right side of runway following loss of braking during landing run. Nosewheels departed paved surface. Minor damage to NLG. No injuries to 178 POB. AAIB Formalinvestigation.

200503773	21/05/2005	Accident	ENSTROM	Take-off	Take-off	Loss of power on lift off, together with smoke from LH engine cowling and air intake. Exhaust pipe from turbocharger found detached. No injury to 2 POB. AAIB AARF investigation.
200503794	21/05/2005	Accident	EUROPA	Approach	Approach	UK Reportable Accident: On approach, engine failed to respond to throttle movements. Successful forced landing madeinto field. AAIB AARF investigation.

200503983	29/05/2005	Accident	AVIONS ROBIN	Landing	Landing	Brake failure on landing. Aircraft overran runway into bushes. Substantial damage. Minor injuries to 2 POB. AAIB Field investigation.
200504012	31/05/2005	Accident	PIPER	Take-off	Take-off	Aircraft damaged during rejected take off, following forced landing due to rough running engine. No injuries to 2 POB. AAIB AARF investigation.
200504329	09/06/2005	Accident	OTHER	Take-off	Take-off - initial climb	AAIB Initial Notification: After glider launch, airbrakesopened in flight. Glider crashed through fence. Aircraft destroyed. Minor injury to 1 POB. Subject to BGA investigation.
200504427	11/06/2005	Accident	BAE	Landing	Landing	AAIB Initial Notification: NLG failed to extend. Divertedto Durban and landing carried out with NLG retracted. Extent of damage unknown.

200504445	11/06/2005	Accident	LANCAIR	Landing	Landing	Nosewheel detached after landing and propeller struck ground. No injury to 1 POB. AAIB AARF investigation.
200504603	10/06/2005	Accident	BAE	Landing	Landing	AAIB Initial Notification: High pressure hydraulic line ruptured at end of landing roll-out. Skydrol breached cabin. 60 POB, 2 minor injuries.
200504636	17/06/2005	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Engine stopped during climb due to fuel starvation caused by an obstruction to the fuel flow. NLG collapsed during forced landing. No injury to 1 POB. AAIB AARF investigation.

200504693	19/06/2005	Accident	HAWKER SIDDELEY	Landing	Landing	AAIB Initial Notification: On landing mainwheel failed torotate. Aircraft slid on R/W surface for a distance of approx 900 metres. Brakes found jammed - no anti-skid operation.
200504897	25/06/2005	Serious incident	AIRBUS	Approach	Approach	Following an ATC initiated go-around from 200ft a MAYDAY was declared due to serious navigational instrument problems. AAIB Field investigation.
200505054	26/06/2005	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Engine failed during initial climb. NLG collapsed and right wing damaged during forced landing in field. No injury to 2 POB. AAIB AARF investigation.

200500619	28/01/2005	Accident	HAWKER SIDDELEY	Take-off	Take-off	The LH overwing emergency exit separated from the aircraft unnoticed during take off. Mail bags fell from the aircraft en route. AAIB Field investigation.
200500951	10/02/2005	Serious incident	DE HAVILLAND	Take-off	Take-off	Following an abandoned take off and subsequent taxi, aircraft was shut down due to smoke in the cabin. AGI initiated. Passengers disembarked on taxiway. AAIB AARF investigation.

200501076	15/02/2005	Accident	DE HAVILLAND	Landing	Landing	RH MLG collapsed during touch and go landing. No injury to 2 POB. AAIB AARF investigation.
200505165	02/07/2005	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Engine stopped during climb out. Aircraft tipped onto nose during forced landing. Substantial damage. No injury to 1 POB. AAIB AARF investigation.

200505438	09/07/2005	Accident	SCHEIBE	Take-off		UK Reportable Accident: Engine failed immediately after take off. Aircraft struck airfield boundary fence. Substantial damage. Minor injury to 1 POB. AAIB AARF investigation.
200507271	04/09/2005	Accident	CESSNA	Landing	Landing	Main landing gear failed to fully extend and collapsed asaircraft landed on grass to side of runway. Substantial damage. No injury to 1 POB. AAIB AARF investigation.
200507591	14/09/2005	Accident	DE HAVILLAND	Take-off	Initial climb	Engine lost power after take off. Aircraft landed heavily, LH MLG collapsed and propeller struck ground. 2 POB - 1 minor injury. AAIB AARF investigation.
200507856	21/09/2005	Accident	AIRBUS	Landing	Landing	AAIB Initial Notification: Caution light noted when landing gear retracted after take-off. Fuel burnt off. Aircraftdiverted to Los Angeles and landed with NLG cocked 90deg.No injuries to 145 POB.

200507973	27/09/2005	Accident	PIPER	Landing	Landing	NLG collapsed on landing. Substantial damage. No injuriesto 2 POB. AAIB AARF investigation.
200508496	09/10/2005	Accident	THORP	Approach	Approach	Aircraft returned due to oil leak. On final approach aircraft stalled and landed in a field 50m short of threshold.Substantial damage. No injury to 1 POB. AAIB AARF investigation.
200505639	13/07/2005	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: MW6 Merlin's engine stopped at 200ft after take-off. A/c stalled at low level and crashed, sustaining extensive damage. Minor injury to 1 POB. AAIB AARF investigation.

200505670	16/07/2005	Accident	OTHER	Landing	Landing	Hand grip detached from control column during flare. Aircraft pitched nose down and overturned. Substantial damage.Minor injury to 1 POB. AAIB AARF investigation.
200505680	16/07/2005	Accident	BELL	Landing	Landing	Intermittent engine out warning followed by lower rotor rpm warning. Main rotor struck tail pylon during autorotation. Substantial damage. No injuries to 4 POB. AAIB AARF investigation.
200508706	22/10/2005	Accident	PIPER	Take-off	Initial climb	Engine failed during initial climb. Following partial power recovery, pilot attempted to turn back but a/c stalled,crashed and was destroyed. Two POB fatal. AAIB Field investigation.

200508981	31/10/2005	Accident	CESSNA	Landing	Landing	Landing gear failed to extend. MAYDAY declared. Aircraft diverted to Cambridge and made wheels up landing on grass.No injury to 1 POB. AAIB AARF investigation.
200509279	09/11/2005	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Pegasus Flash microlight overturned during forced landing following engine failure after take off. Substantial damage. Minor injury to 1 POB. AAIB AARF investigation.
200509360	12/11/2005	Accident	EUROPA	Take-off	Initial climb	Engine lost power after take off due to fuel contamination. During forced landing, a/c struck a wall & was destroyed. No injury to 1 POB. AAIB AARF investigation.
200509792	28/11/2005	Accident	CESSNA	Landing	Landing	Unable to obtain 3 greens on landing gear extension. Low passes and recycling carried out. NLG failed to fully extend and collapsed on landing. No injury to 2 POB. AAIB AARFinvestigation.

200701449	20/02/2007	Serious incident	BAE	Landing	Landing	Spoilers failed to deploy on landing. Emergency braking used. All four MLG tyres burst due no anti-skid. A/c came to rest in undershoot area. AAIB Formal investigation.
200510837	21/08/2005	Accident	PIPER	Landing	Landing	Loss of right rudder authority in flight. On landing a/c weathercocked left and struck a ditch. Damage to propeller, RH MLG spat and wing surfaces. No injury to one POB. Irish authority investigation.
200505944	23/07/2005	Accident	SOCATA	Take-off	Take-off	On take off a/c failed to get airborne & overran R/W intoditch. Substantial damage. Serious injuries to 2 POB. AAIB AARF investigation.

200506142	30/07/2005	Serious incident	BOEING	Take-off	Take-off	Sparks/flames evident from RH MLG during touch and go landing. Circuit flown with gear down and aircraft landed safely. Nr3 brake unit failed. AAIB AARF investigation.
200506230	04/08/2005	Accident	EXTRA	Landing	Landing	RH MLG failed on landing. Substantial damage. No injury to 1 POB. AAIB AARF investigation.

200506295	06/08/2005	Accident	CESSNA	Approach	Circuit pattern - base leg	UK Reportable Accident. MAYDAY declared due to severe engine vibration and loss of airspeed. Aircraft damaged during forced landing in field. No injury to two POB. AAIB AARFinvestigation.
200701945	07/03/2007	Accident	OTHER	Landing	Landing	NLG collapsed on landing. Substantial damage. No injuriesto two POB. AAIB AARF investigation.

200506349	07/08/2005	Accident	AVIONS ROBIN	Take-off	Initial climb	Aircraft caught fire on take off. Aircraft relanded successfully but was destroyed by fire. No injury to 1 POB. AAIB AARF investigation.
200702180	13/03/2007	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Skyranger microlight suffered engine failure shortly after take-off. Landing gear collapsedduring forced landing. No injury to one POB. AAIB AARF investigation.
200702355	19/03/2007	Serious incident	LOCKHEED	Take-off	Take-off	PAN declared due to erratic indications on all four engines. Nr2 shutdown and nrs 1 and 3 ran down during return. Propeller synchrophaser unit failed. AAIB Field investigation.

200702552	25/03/2007	Accident	PIPER	Approach	Approach	UK Reportable Accident: Engine stopped on approach. A/c landed in field and landing gear collapsed. Substantial damage. No injury to one POB. AAIB AARF investigation.
200702567	24/03/2007	Accident	BEECH	Landing	Landing	NLG failed to retract after take-off and would not lock down thereafter. A/c diverted and NLG collapsed on landing.No injuries to seven POB. AAIB Field investigation.
200702614	26/03/2007	Accident	PIPER	Landing	Landing	UK Reportable Accident: PAN declared due to rough runningengine. A/c struck trees during forced landing. Substantial damage. No injuries to two POB.
200702652	28/03/2007	Accident	OTHER	Approach	Circuit pattern - base leg	Propeller blade detached from hub following touch and go.A/c struck hedge during forced landing and was destroyed.No injury to one POB. AAIB AARF investigation.

200703056	07/04/2007	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Engine failed shortly after take-off. A/c struck ditch during forced landing and LH MLG collapsed. Substantial damage. No injuries to two POB. AAIB AARF investigation.
200703267	17/04/2007	Accident	OTHER	Take-off	Initial climb	A/c crashed following loss of engine power shortly after take-off. A/c destroyed. One POB fatal. AAIB Field investigation.
200703268	07/04/2007	Accident	RANS	Take-off	Initial climb	UK Reportable Accident: Engine stopped during climb out. Forced landing made in field. Landing gear collapsed. No injury to one POB. AAIB AARF investigation.
200703307	18/04/2007	Accident	PIPER	Take-off	Take-off	A/c bounced on landing and LH MLG collapsed. No injuries to two POB. AAIB AARF investigation.
200700340	12/01/2007	Serious incident	BAE	Take-off	Initial climb	Pitch control problem due to interference between elevator trim and engine condition lever. A/c returned. AAIB AARFinvestigation.

200700431	17/01/2007	Serious incident	CANADAIR	Landing	Landing	On landing smoke was observed coming from the landing gear. A/c veered off runway. Pilot reported loss of steering.No injuries to 34 POB. AAIB Field investigation.
200700509	21/01/2007	Accident	CESSNA	Landing	Landing	RH MLG collapsed on landing. Damage to right wing and propeller. No injuries to two POB. AAIB Field investigation.
200703393	22/04/2007	Accident	OTHER	Approach	Approach	UK Reportable Accident: Glider dived into ground on approach. A/c destroyed. Serious injury to one POB. Subject to AAIB Field investigation.

200705100	09/06/2007	Accident	OTHER	Landing	Landing	Landing gear seized while partially extended and collapsed during subsequent landing. No injuries to two POB. AAIB Field investigation.
200705490	17/06/2007	Serious incident	SHORT	Approach	Approach	AAIB Initial Notification: Nr1 engine failed on approach.Parts ejected through exhaust, which caught fire. Fire drill actioned successfully. No injuries to 30 POB. Seychelles Authority investigation.
200706423	11/07/2007	Accident	ROCKWELL	Landing	Landing	LH MLG and NLG collapsed during landing roll. Substantialdamage. No injuries to three POB. AAIB AARF investigation.
200706734	19/07/2007	Accident	PIPER	Landing	Landing	RH MLG failed to extend due to failure of associated hydraulic actuator and consequent loss of hydraulic fluid. Substantial damage. No injuries to two POB. AAIB AARF investigation.

200704218	14/05/2007	Accident	PITTS	Take-off	Take-off	Shortly after take-off a loss of propeller thrust occurred. A/c landed back on disused part of runway. Substantial damage. No injuries to two POB. AAIB Field investigation.
200707490	08/08/2007	Accident	PIPER	Take-off	Initial climb	UK Reportable Accident: Engine lost power during go-around. A/c stalled, crashed and was destroyed by fire. Seriousinjury to one POB. AAIB Field investigation.
200707712	12/08/2007	Accident	OTHER	Landing	Landing	UK Reportable Accident: One engine ran down due to icing.A/c returned, landed long and overran runway. NLG collapsed. No injuries to 14 POB. AAIB Field investigation.

200707715	11/08/2007	Accident	OTHER	Approach	Approach	UK Reportable Accident: Chevvron 2-32 microlight sufferedengine failure on final approach due to carburettor icing. A/c damaged during forced landing. No injuries to two POB. AAIB AARF investigation.
200708281	28/08/2007	Accident	AIRBUS	Landing	Landing	Nr2 tyre tread shed during landing, causing damage to left engine, left flap and hydraulic lines in left wheel well. No injuries to 213 POB. AAIB AARF investigation.
200708446	29/08/2007	Accident	JODEL	Landing	Landing	A/c overturned on landing after passenger door opened during initial climb. Substantial damage. No injury to one POB. AAIB AARF investigation.
200711212	08/07/2007	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Thruster microlight suffered lossof engine power on take-off. A/c clipped hedge and overturned. Minor damage. Minor injury to one POB. BMAA/AAIB AARF investigation.
200704457	22/05/2007	Accident	HAWKER	Take-off	Take-off	RH brake seized on take-off. A/c veered off runway, RH MLG collapsed and fuel tank burst. Substantial damage. No injuries to two POB. AAIB AARF investigation.
200704501	23/05/2007	Accident	EUROPA	Landing	Landing	Wheels up landing due to seizure of landing gear extension/retraction system. Substantial damage. No injury to one POB. AAIB AARF investigation.

200704819	29/05/2007	Accident	RANS	Take-off	Initial climb	MAYDAY declared due to propeller separation at about 400-500ft agl. A/c returned and landed safely with AFS in attendance. No injuries to two POB. AAIB AARF investigation.
200709790	06/10/2007	Accident	CESSNA	Landing	Landing	UK Reportable Accident: LH MLG failed to lock down, was out of alignment on approach and collapsed on landing. Substantial damage. No injuries to three POB. AAIB Field investigation.
200708768	07/09/2007	Accident	OTHER	Landing	Landing	AAIB Initial Notification: Landing gear collapsed on landing into sun. Substantial damage. No injury to one POB. Subject to BGA investigation.
200710412	20/10/2007	Accident	OTHER	Take-off	Take-off	Following touch-and-go, Easy Raider microlight became airborne at low speed, stalled and crashed. A/c destroyed. Noinjuries to two POB. AAIB AARF investigation.
200711047	02/11/2007	Accident	CESSNA	Landing	Landing	Rough running engine. NLG failed and a/c overturned during forced landing. Substantial damage. Minor injury to one POB. AAIB AARF investigation.

200711154	09/11/2007	Accident	AIRBUS	Landing	Landing	AAIB Initial Notification: R/W excursion due suspected tyre failure on landing. Reported engine surge/flameout. Substantial damage. No injuries to 349 POB. Subject to Foreign authority investigation.
200711418	20/11/2007	Serious incident	AEROSPATIALE	Take-off	Initial climb	Serious Incident: Nr2 engine freewheel failed during simulated nr1 engine failure. A/c dropped to runway from 30-40ft. No damage or injuries reported. AAIB Field investigation.
200709088	16/09/2007	Accident	PIPER	Approach	Approach	Engine lost power on approach. During forced landing the a/c passed through a hedge and its wings were torn off. Minor injuries to two POB. AAIB AARF investigation.
200712196	01/12/2007	Accident	WITTMAN	Landing	Landing	UK Reportable Accident: RH MLG fractured and collapsed after landing. Substantial damage. No injuries to two POB. AAIB AARF investigation.

200712235	12/12/2007	Accident	PIPER	Landing	Landing	UK Reportable Accident: NLG collapsed on landing. Substantial damage. No injuries to three POB. AAIB AARF investigation.
200712610	30/12/2007	Accident	OTHER	Approach	Circuit pattern - base leg	UK Reportable Accident: Dyn'Aero MCR-01 microlight tailplane separated in flight due to failure of attachment lugs.A/c destroyed. Serious injuries to two POB. AAIB Field investigation.
200712614	31/12/2007	Accident	CESSNA	Landing	Landing	UK Reportable Accident: NLG collapsed on landing. Nose cone and propellers damaged. No injury to one POB. AAIB Field investigation.

200709499	30/09/2007	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Engine lost power shortly after take-off. A/c returned but was forced to go-around and crashed into tree. 2 POB, 1 fatal and 1 serious injury. AAIB Field investigation.
200709720	23/09/2007	Serious incident	BOEING	Approach	Approach	Serious Incident: Uncommanded autothrottle disengagement on approach. During go-around excessive pitch up/stall occurred. Recovery effected and a/c landed safely. AAIB Formal investigation.
200810896	04/10/2008	Accident	PIPER	Landing	Landing	UK Reportable Accident: NLG collapsed on landing. Damage to nose leg, cowling and propeller. No injury to one POB. AAIB AARF investigation.
200811017	08/10/2008	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Aircraft crash landed after take-off. Pilot suspects drop in fuel pressure. Substantial damage. Serious injury to one POB. AAIB Field investigation.

200811140	12/10/2008	Accident	STOLP STARDUSTER	Landing	Landing	UK Reportable Accident: A/c bounced on landing, LH MLG collapsed, a/c departed runway then RH MLG collapsed. No injury to one POB. AAIB AARF investigation.
200811507	17/10/2008	Accident	STODDARD HAMILTON	Approach	Approach	UK Reportable Accident: Engine failure on approach. A/c landed short and came to rest inverted. Substantial damage.Minor injuries to two POB. Subject to Spanish Authority investigation.
200811643	18/10/2008	Serious incident	HAWKER	Landing	Landing	Serious Incident: On landing, the a/c's external fuel tank, which was empty, separated. Runway inspection revealed one edge light u/s and some surface damage. AAIB Field investigation.
200812079	04/11/2008	Accident	CIRRUS	Take-off	Initial climb	UK Reportable Accident: Engine lost power shortly after take-off. MAYDAY declared. A/c hit tree during forced landing. 2 POB - 1 serious, 1 minor injury. Substantial damage.AAIB Field investigation.
200812391	12/11/2008	Accident	PIPER	Landing	Landing	UK Reportable Accident: Loud bang heard on landing gear extension followed by 'gear unsafe' warning. LH MLG collapsed on landing. Substantial damage. No injuries to three POB. AAIB AARF investigation.

200810082	14/09/2008	Accident	DE HAVILLAND	Take-off	Initial climb	UK Reportable Accident: Engine failed at about 80ft during initial climb and aircraft landed in field. Damage to left wing. No injuries to two POB. AAIB AARF investigation.
200813002	04/12/2008	Accident	OTHER	Approach	Approach	UK Reportable Accident: Engine failed on final approach. Forced landing carried out in field. Damage to NLG, RH MLGand wing tip. No injuries to two POB. AAIB AARF investigation.
200813337	18/11/2008	Accident	STODDARD HAMILTON	Landing	Landing	UK Reportable Accident: NLG collapsed on landing and propeller struck ground. No injuries to two POB. NLG damaged and engine shockloaded. AAIB AARF investigation.
200810225	18/09/2008	Accident	OTHER	Take-off	Take-off	UK Reportable Accident: Engine lost power shortly after take-off. A/c struck hedge and was destroyed. Two POB - oneserious and one minor injury. AAIB AARF investigation.

200810300	20/09/2008	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Engine lost power during initial climb. During precautionary landing in field, LH mainwheelentered soft ground and axle failed. No injury to one POB. AAIB AARF investigation.
200801467	16/02/2008	Accident	PIPER	Landing	Landing	AAIB Initial Notification: RH engine RPM began to fluctuate on approach. A/c landed heavily and departed runway. Substantial damage. No injuries to three POB. Irish AAIU investigation.
200800296	12/01/2008	Accident	PIPER	Landing	Landing	UK Reportable Accident: Following a loss of electrical power the landing gear failed to fully extend and collapsed on landing. No injuries to two POB. AAIB AARF investigation.

200802545	14/03/2008	Serious incident	CESSNA	Approach	Approach	Severe control difficulties. Required to land immediately. Landing gear initially failed to extend although it did just prior to landing. Two POB, no injuries. AAIB Field investigation.
200803019	30/03/2008	Accident	CESSNA	Approach	Approach	UK Reportable Accident: A/c crashed into housing estate during in-flight return due to perceived engine vibration. A/c destroyed by fire. Five POB, all with fatal injuries. AAIB Formal investigation.
200803284	05/04/2008	Accident	BEECH	Landing	Landing	UK Reportable Accident: Landing gear collapsed on landing. Substantial damage. No injury to one POB. AAIB Field investigation.

200800448	17/01/2008	Accident	BOEING	Approach	Approach	UK Reportable Accident: Engines failed to respond to power demands. A/c lost speed and landed short of runway. A/c destroyed. 152 POB - 1 serious and 12 minor injuries. AAIBFormal investigation.
200803995	24/04/2008	Accident	CESSNA	Landing	Landing	UK Reportable Accident: MLG retracted on landing. Substantial damage. No injuries to three POB. AAIB Field investigation.
200804120	26/04/2008	Accident	RANS	Take-off	Initial climb	UK Reportable Accident: Engine stopped at 100ft during climb out and a/c dropped to the ground. NLG folded and pushed up the lower frame. No injury to one POB. AAIB AARF investigation.

200804186	30/04/2008	Accident	OTHER	Approach	Circuit pattern - base leg	UK Reportable Accident: Gemini Flash microlight struck a fence during forced landing following engine failure. A/c destroyed. Two POB - one minor injury. AAIB AARF investigation.
200804830	16/04/2008	Accident	OTHER	Landing	Landing	UK Reportable Accident: Streak Shadow microlight NLG collapsed on landing due to fractured shaft. No injury to one POB. AAIB AARF investigation.
200800742	28/01/2008	Accident	AVIONS ROBIN	Landing	Landing	UK Reportable Accident: RH MLG collapsed following slightly heavy landing. Substantial damage. No injuries to two POB. AAIB AARF investigation.
200800802	29/01/2008	Accident	BOMBARDIER	Landing	Landing	LH tyre burst on landing. Flap drive shaft sheared and hydraulic pipes damaged. AAIB Field investigation.

200805617	10/05/2008	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Mainair Rapier microlight lost power during climb out, descended and struck trees at end ofrunway. Substantial damage. Minor injury to one POB. AAIBAARF investigation.
200804346	05/05/2008	Accident	DE HAVILLAND	Take-off	Initial climb	UK Reportable Accident: Loss of power following take-off.Forced landing in crop field. Substantial damage. No injuries to two POB. AAIB AARF investigation.
200806174	14/06/2008	Accident	OTHER	Landing	Landing	UK Reportable Accident: Lower part of RH MLG separated onlanding and aircraft overturned. Minor injuries to three POB. Aircraft destroyed. AAIB Field investigation.
200806495	19/06/2008	Accident	YAKOVLEV	Landing	Landing	UK Reportable Accident: LH MLG failed to extend. Fuel burnt off and wheels up landing carried out. Substantial damage. No injury to one POB. AAIB AARF investigation.

200806731	25/06/2008	Accident	BEECH	Approach	Approach	UK Reportable Accident: On approach, pilot unhappy with LH landing gear. Returned to departure airport. LH landing gear collapsed. 1 POB, no injury. Wing damaged. AAIB Fieldinvestigation.
200806884	28/06/2008	Accident	MORANE SAULNIER	Landing	Landing	UK Reportable Accident: NLG collapsed during landing run.Substantial damage. No injury to one POB. AAIB AARF investigation.
200806913	30/06/2008	Accident	PIPER	Landing	Landing	LH MLG collapsed on landing following possible damage sustained during touch and go training. Substantial damage. No injuries to three POB. AAIB AARF investigation.
200807173	04/07/2008	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Engine lost power during climb out. A/c struck tree and came to rest in a field. A/c destroyed by post-impact fire. No injuries to two POB. AAIB AARFinvestigation.
200807361	10/07/2008	Accident	PIPER	Landing	Landing	UK Reportable Accident: Wheels up landing. Substantial damage. No injuries to two POB. AAIB AARF investigation.
200807406	13/07/2008	Accident	EUROPA	Landing	Landing	UK Reportable Accident: RH MLG outrigger failed to lock down on landing and a/c departed runway. Propeller and wingdamaged. No injuries to two POB. AAIB AARF investigation.

200807427	13/07/2008	Accident	NORTH AMERICAN	Approach	Approach	UK Reportable Accident: A/c struck raised taxiway and LH MLG dug into grass runway following power loss on approach. Substantial damage. No injury to one POB. AAIB AARF investigation.
200804688	10/05/2008	Accident	CESSNA	Landing	Landing	UK Reportable Accident: RH MLG failed to lock down and collapsed on landing. Substantial damage. No injury to one POB. AAIB AARF investigation.
200807762	21/07/2008	Accident	OTHER	Landing	Landing	UK Reportable Accident: RH MLG support partially failed during take-off. Landing gear collapsed on subsequent landing. Substantial damage. No injuries to two POB. AAIB AARF investigation.
200807949	27/07/2008	Accident	SHORT	Landing	Landing	UK Reportable Accident: Following a heavy landing, after which it was confirmed that the RH MLG was damaged, a further flight was conducted. No injury to one POB. AAIB Fieldinvestigation.

200808293	01/08/2008	Serious incident	EMBRAER	Landing	Landing	UK Serious Incident: MAYDAY declared. Aircraft diverted due to burning smell / fumes on flight deck and smoke in the cabin. Crew used oxygen. Uneventful landing. AAIB Field Investigation.
200808384	04/08/2008	Accident	GROB	Landing	Landing	UK Reportable Accident: On firm but not heavy landing, RHwheel detached from the landing gear leg. Two POB, no injuries. AAIB AARF investigation.
200808901	15/08/2008	Accident	OTHER	Take-off	En-route	UK Reportable Accident: Aircraft lost power during go-around and made a forced landing in a field. Minor damage. Noinjury to one POB. AAIB AARF investigation.
200808901	15/08/2008	Accident	PIPER	Approach	Approach	UK Reportable Accident: Aircraft lost power during go-around and made a forced landing in a field. Minor damage. Noinjury to one POB. AAIB AARF investigation.

200805424	29/05/2008	Accident	AIRBUS	Take-off	Take-off	AAIB Initial Notification: Smoke from/damage to LH MLG/tyres after rejected take-off. A/c stopped on taxiway. Precautionary disembarkation. No injuries to 250 POB. AAIB Field investigation.
200805475	31/05/2008	Accident	JODEL	Landing	Landing	UK Reportable Accident: Engine lost power on approach. A/c landed short on soft ground and overturned. Minor injuryto one POB. AAIB AARF investigation.
200805544	31/05/2008	Accident	OTHER	Landing	Landing	UK Reportable Accident: Landing gear collapsed on landing. No injuries to two POB. AAIB AARF investigation.
200404942	23/07/2004	Accident	BRITTEN NORMAN	Take-off	Initial climb	UK Reportable Accident: De-icer boot separated from LH propeller during climb, breaking a cabin window and enteringthe cabin. One passenger seriously injured. AAIB Formal investigation.

200601690	04/03/2006	Accident	SCHEIBE	Approach		Propeller separated in flight. A/c landed safely without further damage or injury to 1 POB. AAIB AARF investigation.
200601693	05/03/2006	Accident	EUROPA	Take-off	Initial climb	Engine began to misfire and lose power. Return initiated but forced landing became necessary, during which a/c was substantially damaged. Minor injuries to 2 POB. AAIB AARF investigation.
200601199	15/02/2006	Serious incident	BAE	Approach	Approach	Loud bang on short finals followed by loss of yellow hydraulic system/contents. Hydraulic accumulator exploded, piercing pressure hull. AAIB AARF investigation.

200601214	16/02/2006	Accident	SOCATA	Take-off	Take-off	On applying take off power a propeller blade detached, the crankshaft fractured and the engine partially separated.No injuries to two POB. AAIB Field investigation.
200601945	10/03/2006	Accident	BAE	Landing	Landing	AAIB Initial Notification: Landing gear unsafe indicationfollowing retraction. Aircraft returned. NLG collapsed onlanding. Subject to Foreign authority investigation.
200602454	29/03/2006	Serious incident	FOKKER	Approach	Approach	AAIB Initial Notification: Ailerons unmovable during approach. PAN declared. Aircraft landed safely. Investigation delegated to Dutch authority.
200602833	08/04/2006	Accident	PIPER	Landing	Landing	RH MLG collapsed during landing run. No injuries to 2 POB. AAIB AARF investigation.
200602871	10/04/2006	Accident	PIPER	Landing	Landing	NLG collapsed on landing. No injury to 2 POB. AAIB AARF investigation.
200603067	16/04/2006	Accident	VANS	Approach	Approach	Loss of control in the flare due to disconnection of RH 'plug-in' stick. Substantial damage. No injuries to two POB. AAIB Field investigation.

200603755	09/05/2006	Accident	HUGHES	Landing	Landing	Engine power began to fluctuate erratically during approach. Pilot entered autorotation but helicopter landed heavily, rolled over and was destroyed. No injury to one POB. AAIB Field investigation.
200604320	25/05/2006	Accident	CESSNA	Take-off	Initial climb	UK Reportable Accident: Engine failure after take off. Forced landing in field. A/c landed heavily, NLG collapsed and a/c overturned. Minor injuries to two POB. AAIB AARF investigation.
200604389	28/05/2006	Serious incident	AIRBUS	Take-off	Initial climb	AAIB Initial Notification: RH engine failure after take off. Aircraft returned. Engine fire not contained. No injuries to 221 POB. Subject to Foreign authority investigation.
200604492	27/05/2006	Accident	EUROPA	Landing	Landing	Castoring nosewheel separated from NLG on normal smooth landing due roll pin failure. Propeller contacted runway. No reported injuries. AAIB Field investigation.
200604933	12/06/2006	Accident	OTHER	Landing	Landing	NLG wheel fork arms failed and nosewheel separated duringlanding run. Substantial damage. No injuries to two POB. AAIB Field investigation.

200605351	22/06/2006	Serious incident	DORNIER	Landing	Landing	Pilot unable to release power lever latches on landing. A/c overran R/W, coming to rest 350m into rough grass. No damage and no injuries to 19 POB. AAIB Field investigation.
200605569	29/06/2006	Accident	PIPER	Take-off	Initial climb	Suspected loss of engine power on take-off. A/c returned but bounced on landing. Go-around initiated during which a/c stalled, crashed and caught fire. One POB fatal. AAIB Field investigation.
200605757	04/07/2006	Accident	BEECH	Landing	Landing	NLG failed to lock down and collapsed on landing. Substantial damage. No injury to one POB. AAIB AARF investigation.

200606325	18/07/2006	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Skyranger struck fence and overturned during forced landing after engine seized due to oil starvation. Substantial damage. Minor injury to one POB. AAIB Field investigation.
200606335	12/07/2006	Accident	BRITTEN NORMAN	Take-off	Take-off	AAIB Initial Notification: During night take off, RH engine power fluctuated. Pilot rejected take off and a/c landed heavily. Damage to right wing. No injuries reported.
200606465	21/07/2006	Accident	EUROPA	Take-off	Initial climb	Aircraft forced landed in a field when engine misfired/ran roughly during climb out. Substantial damage. No injuries to two POB. AAIB AARF investigation.
200606532	22/07/2006	Accident	PIPER	Approach	Approach	LH MLG collapsed during landing run. Substantial damage. No injury to one POB. AAIB AARF investigation.
200606954	02/08/2006	Serious incident	BOEING	Take-off	Initial climb	AAIB Initial Notification: LH engine failure during climb. A/c returned. Damage to LH engine, flaperon and flap. Noinjuries to 310 POB. Subject to Foreign authority investigation.

200607024	06/08/2006	Accident	OTHER	Approach	Approach	Pilot reported control problems. Aircraft lined up for runway but dived into ground from approx 150ft. One POB fatal. AAIB Field Investigation.
200607047	07/08/2006	Serious incident	AIRBUS	Take-off	Initial climb	AAIB Initial Notification: Nr2 engine failure during climb (approx 1000ft). A/c returned and landed safely. HP turbine 1st stage blade failure. Subject to French Authority (BEA) investigation.
200607138	31/07/2006	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Skyranger 912(2) microlight engine failure after take-off. A/c stalled and landed heavily. Substantial damage. No injuries to 2 POB. Subject to French BEA investigation.
200607768	30/08/2006	Accident	PIPER	Take-off	Take-off	UK Reportable Accident: Engine failed after take off. A/clanded on runway but failed to stop, passed through hedgeand overturned. Substantial damage. No injuries to 3 POB.AAIB Field investigation.
200609851	01/08/2006	Accident	BAE	Take-off	Take-off	AAIB Initial Notification: LH nosewheel separated during take-off. A/c returned and landed safely following tower flypast inspection. No injuries to 26 POB. Subject to Foreign Authority investigation.

200608062	07/09/2006	Accident	YAKOVLEV	Landing	Landing	Wheels-up landing after landing gear failed to extend using normal and emergency systems. Cause of landing gear failing to extend is unknown. No injuries to 2 POB. AAIB AARFinvestigation.
200608653	23/09/2006	Accident	BOLKOW	Take-off	Initial climb	NLG detached during climb out due to fatigue failure of outer tube. Substantial damage. No injury to 1 POB. AAIB Field investigation.
200608662	25/09/2006	Accident	SOCATA	Approach	Approach	MAYDAY declared due to engine power loss. A/c crashed into trees, caught fire and was destroyed. Serious injury to one POB. AAIB Field investigation.

200609304	12/10/2006	Serious incident	LOCKHEED	Take-off	Take-off	Nr3 engine cowlings separated from aircraft during taxi out. Flight continued to destination and landed safely. Airstarter motor gearbox failure. AAIB Field investigation.
200609321	13/10/2006	Accident	AEROSPATIALE	Take-off	Take-off	Take-off rejected due to severe vibration following loud bang. Main rotor head spindle fractured. No injury to 13 POB. AAIB Field investigation.
200609362	13/10/2006	Accident	OTHER	Landing	Landing	NLG failed on landing. Damage to propeller and engine mounting. No injury to one POB. AAIB AARF investigation.
200609397	15/10/2006	Accident	RANS	Take-off	Initial climb	Engine failed shortly after take off. Wing touched ground, a/c cartwheeled and was destroyed. Minor injuries to twoPOB. AAIB AARF investigation.

200609462	18/10/2006	Serious incident	AIRBUS	Approach	Approach	AAIB Initial Notification: Go-around carried out on approach due to being too high and fast. Advanced throttle for power but nr2 engine showed failure message. Shut down engine. Aircraft landed safely
200608884	30/09/2006	Accident	PIPER	Landing	Landing	Aircraft veered off runway during landing roll and struckgrass bank. NLG and LH MLG detached. No injuries to two POB. AAIB AARF investigation.
200610054	04/11/2006	Serious incident	OTHER	Take-off	Take-off	AAIB Initial Notification/Serious Incident: Rear canopy opened during winch launch. Canopy damaged. No injuries to 1 POB. Subject to BGA investigation.
200610953	04/12/2006	Accident	OTHER	Take-off	Initial climb	Engine failure after take off. Forced landing in field. NLG dug in and collapsed. Substantial damage. No injuries to two POB. AAIB AARF investigation.
200611088	07/12/2006	Serious incident	BOEING	Take-off	Take-off	Serious Incident: Both stick shakers began to operate continuously just before V1. Take-off continued, fuel dumped and a/c returned. RH ADC replaced but fault recurred. AAIBField investigation.

200611330	13/12/2006	Accident	DE HAVILLAND	Take-off	Initial climb	RH inboard mainwheel separated on take-off due to bearingfailure. A/c returned and landed safely. Damage to wheel and axle. No injuries to 37 POB. AAIB AARF investigation.
200611819	29/12/2006	Serious incident	EMBRAER	Landing	Landing	Rudder hardover protection system (RHPS) tripped on landing, resulting in loss of hydraulic power to the rudder. AAIB Field investigation.
200611986	29/10/2006	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Quad City Challenger microlight engine failed shortly after take-off. NLG and LH MLG damaged during forced landing. No injuries to two POB. AAIB AARFinvestigation.
200900019	02/01/2009	Serious incident	BOEING	Take-off	Take-off	Serious Incident: Power surge in RH engine on take-off. Take-off aborted. Passengers deplaned without injury. Possibly uncontained - impact dent in fuselage. Subject to overseas investigation.
200901566	21/02/2009	Accident	OTHER	Approach	Approach	UK Reportable Accident: MAYDAY declared 3mins after take-off. A/c spun in from 300-400ft during attempted return toairfield. One POB fatal. A/c destroyed. AAIB Field investigation.

200901644	21/02/2009	Accident	MAULE	Approach	Approach	UK Reportable Accident: Engine lost power in flight. RH MLG sheared off during forced landing and a/c overturned. Substantial damage. Minor injury to one POB. AAIB AARF investigation.
200901756	26/02/2009	Accident	BEAGLE	Approach	Approach	UK Reportable Accident: Reported engine problem. Attempted forced landing. Came to rest in a ditch. Two POB, one minor & one no injuries. Substantial aircraft damage. AAIB AARF investigation.
200902242	11/03/2009	Accident	HAWKER	Landing	Landing	UK Reportable Accident: A/c pitched nosed down on landingand propeller struck runway. Damage to propeller and landing gear doors. No injury to one POB. AAIB AARF investigation.
200903044	29/03/2009	Accident	JABIRU	Approach	Approach	UK Reportable Accident: Engine failed during approach. A/c struck hedge and overturned. Substantial damage. No injuries to two POB. AAIB AARF investigation.
200903053	02/04/2009	Accident	BEECH	Landing	Landing	UK Reportable Accident: RH MLG failed to extend. Damage to right wing tip and a/c step. No injuries to three POB. AAIB AARF investigation.

200903100	29/03/2009	Accident	CESSNA	Landing	Landing	UK Reportable Accident: Landing gear collapsed on landing. No injury to one POB. AAIB Field investigation.
200903652	19/04/2009	Accident	PIPER	Landing	Landing	UK Reportable Accident: Bang heard on landing. Go-around carried out. ATC noted NLG was misaligned. A/c departed runway on second landing. No injuries to four POB. Subject to AAIB AARF investigation.
200904783	17/05/2009	Accident	GRUMMAN	Landing	Landing	UK Reportable Accident: Aircraft forced landed on disusedairfield due to rough running engine and struck a post. Substantial damage. No injuries to one POB. AAIB AARF investigation.
200905401	30/05/2009	Accident	PIPER	Landing	Landing	UK Reportable Accident: Aircraft landed, taxied and the undercarriage collapsed. Two POB, no injuries. Damage to undercarriage / wheel. AAIB AARF investigation.

200906526	23/06/2009	Accident	OTHER	Approach	Circuit pattern - base leg	UK Reportable Accident: Engine faltered during circuit toland and aircraft forced landed in field. Damage to NLG. No injuries to one POB. AAIB AARF investigation.
200906626	29/06/2009	Accident	JODEL	Take-off	Take-off	UK Reportable Accident: Power loss on take-off. Returned.Landed downwind. Unable to stop. Hit a metal barrier. OnePOB, no injuries. AAIB AARF investigation.
200906721	30/06/2009	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Engine failed shortly after take-off. MAYDAY declared. A/c crashed in garden & was destroyed. Wall & car damaged. Minor injuries to two POB. AAIB Field investigation.
200906775	02/07/2009	Accident	OTHER	Landing	Landing	UK Reportable Accident: A/c swung left on landing and ground looped into a hedge. Substantial damage. No injury to one POB. AAIB AARF investigation.

200906858	04/07/2009	Accident	DE HAVILLAND	Take-off	Initial climb	UK Reportable Accident: On first flight after rebuild, engine lost power in climb and a/c struck trees. All four wings severely damaged. No injuries to two POB. AAIB AARF investigation.
200906970	05/07/2009	Accident	BRITTEN NORMAN	Take-off	Initial climb	Foreign Accident: RH propeller and hub separated during initial climb, striking fuselage and removing passenger door. A/c returned. 11 POB - three minor injuries. New Zealand Authority investigation.
200907301	14/07/2009	Serious incident	JODEL	Approach	Circuit pattern - base leg	UK Serious Incident: PAN declared due to fire in the flight deck flooring. Upgraded to MAYDAY. A/c landed safely. Two POB, no injuries. AAIB AARF Investigation.
200908374	08/08/2009	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Engine failed after take-off. Aircraft landed but overran runway into ditch. Substantial damage. No injuries to two POB. AAIB AARF investigation.

200908790	19/08/2009	Serious incident	ROCKWELL	Landing	Landing	UK Serious Incident: Only 2 gear down reported on finals.Several attempted approaches to check if gear down. A/c landed safely on MLG. Two POB, no injuries. AAIB AARF investigation.
200909211	27/08/2009	Accident	BAC	Landing	Landing	UK Reportable Accident: Loss of control on landing. Veered of runway and struck a fence. One POB, no injuries. AAIBAARF investigation.
200909716	16/08/2009	Accident	BRITTEN NORMAN	Approach	Approach	Reportable Accident: Emergency declared due to double engine failure. A/c ditched approximately 2nm from airport. Ten POB, minor injuries. Substantial a/c damage. Subject toforeign investigation.
200910025	12/09/2009	Accident	BOLKOW	Take-off	Take-off	UK Reportable Accident: Canopy detached at approx 60kts during take-off. Canopy destroyed and leading edge of fin damaged. One POB, no injuries. AAIB AARF investigation.
200910177	17/09/2009	Accident	OTHER	Take-off	En-route	UK Reportable Accident: Power decrease following take-off. A/c landed in field. Propeller, landing gear and cowlingdamaged. No injuries to one POB. AAIB AARF investigation.
200911386	20/10/2009	Accident	CESSNA	Landing	Landing	UK Reportable Accident: Nosewheel failed to extend for landing. Landed nose down on grass runway but scraped acrosstarmac intersection. Two POB, no injuries. AAIB AARF investigation.

200911398	15/10/2009	Accident	RANS	Take-off	Take-off	UK Reportable Accident: A/c lost power during take-off roll, pulled to left and departed runway into ploughed field. Substantial damage. Two POB, no injuries. AAIB AARF investigation.
200911696	27/10/2009	Accident	PIPER	Landing	Landing	UK Reportable Accident: On landing, a/c skidded on wet runway, crossed the threshold and stopped on an embankment. Two POB, no injuries, one other person, minor injuries. AAIB AARF investigation.
200911728	28/10/2009	Accident	BOEING	Landing	Landing	UK Reportable Accident: Tyre believed to have burst aftertake-off. Upon landing, large piece on metal (6ft x 4ft) believed to be from the a/c found on the runway. AAIB Field investigation.
200911737	25/10/2009	Accident	CESSNA	Landing	Landing	UK Reportable Accident: Nosewheel folded back on touchdown. Propeller damaged, engine shock loaded. One POB, no injuries. AAIB AARF investigation.
200911737	25/10/2009	Accident				UK Reportable Accident: Nosewheel folded back on touchdown. Propeller damaged, engine shock loaded. One POB, no injuries. AAIB AARF investigation.

200911911	29/10/2009	Accident	PIPER	Landing	Landing	UK Reportable Accident: On landing, lower damper attachment sheared off. One POB, no injuries. Damper arm broken, fuselage tube broken. AAIB AARF investigation.
200912796	23/11/2009	Accident	BEECH	Landing	Landing	UK Reportable Accident: No NLG indication on approach. A/c landed with nose gear part retracted. NLG collapsed on landing. Two POB, no injuries. AAIB AARF investigation.
200913245	08/12/2009	Accident	GROB	Landing	Landing	AAIB Reportable Accident: A/c was practising an emergencylanding. Landed but veered off the runway. Two POB, no injuries. Substantial wing damage. AAIB AARF investigation.

200913599	28/12/2009	Accident	MOONEY	Take-off	Initial climb	UK Reportable Accident: Wheels up forced landing due to engine failure at 50ft on climb out. Propeller damaged. OnePOB, no injuries. AAIB AARF investigation.
201100244	08/01/2011	Accident	OTHER	Approach	Approach	UK Reportable Accident: A/c struck fence and crashed during emergency landing following engine failure after take-off. Substantial damage. One POB, no injuries. AAIB AARF investigation.
201101013	01/02/2011	Accident	CESSNA	Landing	Landing	UK Reportable Accident: LH MLG collapsed on landing and a/c departed runway onto grass. Damage sustained. One POB, no injuries. AAIB AARF investigation.
201101142	04/02/2011	Accident	BAE	Landing	Landing	UK Reportable Accident: LH MLG attachment failed whilst landing in strong crosswinds. No reported injuries. AAIB Field investigation.

201102250	07/03/2011	Accident	PIPER	Take-off	Take-off	UK Reportable Accident: A/c performed a touch and go. Nose wheel collapsed during take-off roll. Two POB, no injuries. AAIB AARF investigation.
201103448	02/04/2011	Accident	PIPER	Landing	Landing	Foreign Accident: Landing gear malfunction due to suspected hydraulic leak. Substantial damage. Six POB, no injuries. AAIB/Overseas Territory AARF investigation.
201103889	09/04/2011	Accident	SIAI MARCHETTI	Landing	Landing	UK Reportable Accident: Wheels up landing. Propeller and flaps bent. One POB, no injuries. AAIB AARF investigation.
201104015	15/04/2011	Accident	PIPER	Landing	Landing	UK Reportable Accident: On landing, RH brake failed. A/c drifted left, the LH wingtip hit a tree and the propeller struck the ground. Two POB, no injuries. AAIB AARF investigation.

201104354	24/04/2011	Accident	OTHER	Take-off	Take-off	UK Reportable Accident: A/c veered to the right during touch and go, then appeared to climb. Elected to put down and undercarriage collapsed. Two POB, no injuries. AAIB AARFinvestigation.
201105922	19/05/2011	Accident	CYCLONE AIRSPORTS	Take-off	Take-off	UK Reportable Accident: A/c experienced loss of power at 500ft. A/c landed. Investigation found two compressed plugs. A/c lost power on subsequent flight and landed heavily off aerodrome. AAIB AARF.
201106044	02/06/2011	Accident	CESSNA	Take-off	Initial climb	UK Reportable Accident: A/c crashed in a field whilst returning to airfield following engine problems after take-off. A/c considered destroyed. Two POB, minor injuries. AAIBAARF investigation.
201106291	31/05/2011	Accident	OTHER	Landing	Landing	UK Reportable Accident: MLG retracted on landing after failing to fully extend and lock. Substantial damage. One POB, no injuries. AAIB AARF investigation.

201107202	25/06/2011	Accident	AVIONS ROBIN	Landing	Landing	UK Reportable Accident: Nosewheel support attachment failed on landing. Two POB, no injuries. Damage to nosewheel attachment support and exhaust. Subject to Foreign Authority investigation.
201107227	26/06/2011	Accident	RANS	Take-off	Take-off	UK Reportable Accident: LH wheel jammed on take-off. A/c began to climb, lost speed and stalled. One wing dropped and a/c hit a sea wall. Two POB, no injuries. AAIB AARF investigation.
201107458	03/07/2011	Accident	MONNETT	Take-off	Initial climb	UK Reportable Accident: Engine lost power after take-off and unable to gain height. Crashed into a marsh. One POB, no injuries. Substantial a/c damage. AAIB AARF investigation.
201107516	29/06/2011	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: A/c forced landed in a rape fielddue to engine power loss after take-off. Substantial damage. One POB, no injuries. AAIB AARF investigation.

201107599	03/07/2011	Accident	GLASER DIRKS	Approach		UK Reportable Accident: Extra drag when engine failed to stow caused a/c to undershoot runway and crash through a fence. Substantial damage. One POB, no injuries. Subject toBGA investigation.
201107715	03/07/2011	Accident		Take-off	Initial climb	UK Reportable Accident: Insufficient power on take-off and a/c became tangled in power lines. Rotors damaged. Two POB, one minor injury. AAIB AARF investigation.
201108838	28/07/2011	Serious incident	PIPER	Take-off	Initial climb	Landing gear failed to retract after take-off and then failed to extend. Emergency system used to extend gear and a/c returned. LH engine hydraulic pump seized due to sheared pump drive.
201109293	06/08/2011	Accident	OTHER	Landing	Landing	UK Reportable Accident: A/c lost power, landed in a fieldand tipped over. Substantial damage. One POB, no injuries. AAIB AARF investigation.

201109388	10/08/2011	Accident	PIPER	Landing	Landing	UK Reportable Accident: Landing gear collapsed after landing. Substantial damage. One POB, no injuries. AAIB AARF investigation.
201109928	20/08/2011	Accident	POBEREZNY	Landing	Landing	UK Reportable Accident: During landing RH main landing gear collapsed. Two POB, no injuries. AAIB AARF investigation.
201110661	02/09/2011	Accident	ZENAIR	Take-off	Take-off	UK Reportable Accident: A/c lost power after take-off andlanded back on the field. One POB, no injuries. Landing gear, wings and fuselage damaged. AAIB AARF investigation.
201114461	16/10/2011	Accident	GLASER DIRKS	Landing		UK Reportable Accident: During landing run, the landing gear collapsed. One POB, no injuries. Subject to BGA investigation.
201111978	01/10/2011	Accident	GARDAN	Landing	Landing	UK Reportable Accident: Landing gear collapsed during landing. No injuries to three POB. AAIB AARF investigation.
201000648	25/01/2010	Accident	CESSNA	Landing	Landing	UK Reportable Accident: Nose landing gear collapsed on landing. Two POB, no injuries. NLG, nose cone and both propellers damaged. AAIB AARF investigation.

201000835	30/01/2010	Accident	FOURNIER	Landing		UK Reportable Accident: Heavy landing. Nosewheel and undercarriage damage. One POB, no injuries. AAIB AARF investigation.
201002024	01/03/2010	Accident	OTHER	Landing	Landing	UK Reportable Accident: A/c veered to left on landing (due to punctured LH main tyre), into ploughed field and inverted. Substantial damage. Two POB, no injuries. AAIB AARF investigation.
201002268	13/03/2010	Accident	MORANE SAULNIER	Landing	Landing	UK Reportable Accident: Nosewheel separated following shimmy during fast landing. Substantial damage. Two POB, no injuries. AAIB AARF investigation.
201002784	22/03/2010	Accident	LOCKHEED	Take-off	Initial climb	Foreign Accident: RH engine caught fire on initial climb.Aircraft returned. Subject to Bangladesh Authority (CAAB)investigation.
201003090	07/04/2010	Accident	EXTRA	Landing	Landing	UK Reportable Accident: RH landing gear collapsed on landing. Propeller struck the ground. Two POB, no injuries. RHlanding gear and propeller damaged. AAIB Field investigation.
201003303	11/04/2010	Accident	OTHER	Landing	Landing	UK Reportable Accident: A/c landed and came to a stop on its side. Two POB, both with minor injuries. Wing damaged.AAIB AARF investigation.

201003620	28/04/2010	Serious incident	ILYUSHIN	Take-off	Initial climb	UK Serious Incident: When autopilot turned off, a/c made uncontrolled turn. MAYDAY declared. Fuel dumped. Returned to departure airport. Subject to foreign authority investigation.
201003706	24/04/2010	Accident	YAKOVLEV	Take-off	Take-off	UK Reportable Accident: Forced landing in a field due to loss of engine power. Two POB, no injuries. Propeller damage. AAIB AARF investigation.
201004007	09/05/2010	Accident	CESSNA	Approach	Approach	UK Reportable Accident: A/c crashed during attempted forced landing in a field due to engine malfunction. Two POB, no injuries. AAIB AARF investigation.
201005009	31/05/2010	Accident	BELLANCA	Landing	Landing	UK Reportable Accident: Landing gear collapsed on landing. Landing gear damaged. Two POB, no injuries. AAIB AARF investigation.
201005106	03/06/2010	Accident	DIAMOND	Approach	Approach	UK Reportable Accident: Landing gear would not extend on approach. A/c returned, where it landed with RH MLG up andslewed off to the right. Two POB, no injuries. AAIB FieldInvestigation.

201005715	18/06/2010	Accident	PIPER	Landing	Landing	UK Reportable Accident: Wheels-up forced landing on private airstrip due to LH engine failure. PAN declared. Substantial damage. Two POB, no injuries. AAIB AARF investigation.
201005845	21/06/2010	Accident	PIPER	Landing	Landing	UK Reportable Accident: Landing gear collapsed on landing. Three POB, no injuries. A/c underside, landing gear doors, flaps & step damaged. AAIB AARF investigation.
201005893	18/06/2010	Accident	CESSNA	Landing	Landing	UK Reportable Accident: Nosewheel collapsed on landing. One POB, no injuries. Damage to nosewheel and propeller. AAIB ARF investigation.
201005912	22/06/2010	Accident	PIPER	Approach	Approach	UK Reportable Accident: A/c landed short of the runway. One POB, no injuries. Substantial a/c damage. AAIB AARF investigation.

201005999	18/06/2010	Accident	MORANE SAULNIER	Take-off	Take-off	UK Reportable Accident: Engine failure during touch and go. A/c force landed in field and came to rest in a hedge. Substantial damage. One POB, no injuries. AAIB AARF investigation.
201006076	26/06/2010	Accident	EUROPA	Landing	Landing	UK Reportable Accident: Nose wheel collapsed on landing. One POB, no injuries. Substantial a/c damage. AAIU investigation.
201006159	22/06/2010	Accident	JABIRU	Take-off	Initial climb	UK Reportable Accident: Engine failure after take-off andforced landing made in a field. One POB, no injuries. Wing, landing gear and propeller damaged. AAIB AARF investigation.
201006301	12/06/2010	Accident	YAKOVLEV	Landing	Landing	UK Reportable accident: Landing gear retracted after landing. Minor damage. Two POB, no injuries. Subject to FrenchAuthority (BEA) investigation.
201006555	26/06/2010	Accident	OTHER	Landing	Landing	UK Reportable Accident: Nose gear collapsed on landing. Nose fork, wheel, tyre and pod destroyed. One POB, no injuries. AAIB AARF investigation.
201007110	26/06/2010	Accident	MOONEY	Landing	Landing	UK Reportable Accident: Wheels up landing when landing gear failed to extend due to total electrical failure. Substantial damage. Four POB, no injuries. Subject to French BEA investigation.

201007630	23/07/2010	Accident	JABIRU	Take-off	Take-off	UK Reportable Accident: During a practice take-off, flapsfailed to deploy. A/c collided with a fence and severely damaged. One POB, no injuries. AAIB AARF investigation.
201007936	31/07/2010	Serious incident	AIRBUS	Approach	Approach	UK Serious Incident: A/p disconnected at 200ft. Right sidestick pushed. No response and wings remained level. Full sidestick demanded & a/c responded. Responses then normal.
201007968	31/07/2010	Accident	OTHER	Landing	Landing	UK Reportable Accident: Wheels up landing. Substantial damage. One POB, no injuries. AAIB AARF investigation.
201008685	19/06/2010	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Power loss followed by engine stopping. Forced landing off aerodrome. One POB, minor injuries. AAIB AARF investigation.
201014548	02/08/2010	Accident	AVID	Landing	Landing	UK Reportable Accident: A/c ground looped on landing. TwoPOB, no injuries. AAIB AARF investigation.

201009668	01/09/2010	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: Engine failure during take-off. Forced landing in a field. One POB, no injuries. A/c destroyed. AAIB AARF investigation.
201011123	30/09/2010	Accident	JABIRU	Landing	Landing	UK Reportable Accident: A/c landed and veered to the leftof the runway. Nosewheel caught in runway edge and flipped a/c over. Two POB, both minor injuries. AAIB AARF investigation.
201011384	07/10/2010	Accident	ZENAIR	Take-off	Initial climb	UK Reportable Accident: Engine failure after take-off. Forced landing in a field. One POB, no injuries. Substantiala/c damage. AAIB AARF investigation.
201011648	16/10/2010	Accident	OTHER	Landing	Landing	UK Reportable Accident: A/c rolled over during precautionary landing on beach following indicated engine temperature rise. Substantial damage. Two POB, no injuries. AAIB AARF investigation.

201011696	17/10/2010	Accident	OTHER	Take-off	Take-off	UK Reportable Accident: A/c failed to accelerate as expected and crashed into hedges/trees during aborted take-off.Substantial damage. One POB, no injuries. AAIB AARF investigation.
201012699	10/11/2010	Accident	GRUMMAN	Take-off	Initial climb	UK Reportable Accident: Engine failure during climb out. MAYDAY declared. A/c struck wall during attempted forced landing. Substantial damage. Two POB, no injuries. AAIB AARF investigation.
201013723	09/12/2010	Accident	CESSNA	Landing	Landing	UK Reportable Accident: RH MLG collapsed on landing and a/c came to rest partially off runway. Substantial damage. Two POB, no injuries. AAIB Field investigation.
201013845	10/12/2010	Accident	PIPER	Approach	Circuit pattern - base leg	UK Reportable Accident: Engine power loss during flight. A/c attempted a forced landing in a field but went througha hedge and came to rest on a road. One POB, no injuries.AAIB AARF investigation.

201013940	10/12/2010	Serious incident	CESSNA	Approach	Approach	UK Serious Incident: A/c deviated from localiser on approach. Carried out "unusual manoeuvres", entered an orbit at6 DME followed by heading & altitude changes. AAIB AARF investigation.
201010360	17/09/2010	Accident	AUSTER	Landing	Landing	UK Reportable Accident: Fuel emergency declared. Heavy landing, gear collapsed and a/c slewed off runway. Two POB, no injuries. Landing gear damaged. AAIB AARF investigation.
200600756	31/01/2006	Accident	ROCKWELL	Landing	Landing	NLG collapsed on landing. Substantial damage. No injuriesto 2 POB. AAIB AARF investigation.
200604667	05/06/2006	Accident	DIAMOND	Take-off	Take-off	NLG leg failed during touch and go landing. Aircraft destroyed. No injuries to 2 POB. AAIB AARF investigation.

201203118	25/03/2012	Accident	PIPER	Take-off	Take-off	UK Reportable Accident: Undercarriage collapsed after second touch and go. Two POB, no injuries. Landing gear and wheel damaged. AAIB Field investigation.
201203395	31/03/2012	Accident	OTHER	Take-off	Take-off	UK Reportable Accident. A/c suffered power failure on take-off. A/c landed and went through a fence. Two POB, no injuries. AAIB AARF investigation.
201204123	15/04/2012	Accident	RANS	Take-off	Initial climb	UK Reportable Accident: Forced landing in a field due to rough running engine. Two POB no injuries. Substantial damage to a/c. AAIB AARF investigation.
201205991	29/05/2012	Accident	ZENAIR	Take-off	Initial climb	UK Reportable Accident: The a/c's cockpit canopy became unlatched during climb-out after take-off. Forced landing carried out. Extensive fire. One POB, no injuries. AAIB AARF investigation.
201204612	30/04/2012	Accident	CESSNA	Landing	Landing	UK Reportable Accident. Unable to lower nosewheel for landing. A/c landed with nosewheel retracted. Damage to underside and nose area. 3 POB, no injuries. AAIB AARF investigation.

201205011	06/05/2012	Accident	MAINAIR	Landing	Landing	UK Reportable Accident. Two a/c collided on ground causing extensive damage. One POB on each a/c, one with serious injuries. AAIB AARF Investigation.
201205011	06/05/2012	Accident	SCHLEICHER	Landing	Landing	UK Reportable Accident. Two a/c collided on ground causing extensive damage. One POB on each a/c, one with serious injuries. AAIB AARF Investigation.
201205219	16/05/2012	Accident	CESSNA	Landing	Landing	UK Reportable Accident. Nosewheel shimmy on landing, a/c veered left. Both propellers struck ground and nose collapsed as a/c came to rest on the grass. Three POB no injuries. AAIB AARF investigation.

201207783	24/06/2012	Accident	CHRISTEN	Approach	Approach	UK Reportable Accident: Engine failure during final approach. Aircraft turned over during emergency landing. Two POB, no injuries. Substantial damage.
201206397	09/06/2012	Accident	JODEL	Take-off	Initial climb	UK Reportable Accident: A/c suffered engine problems just after take-off and made a forced landing in a field. Two POB, one minor injuries. Extensive damage to a/c. AAIB AARF Investigation.
201206480	11/06/2012	Accident	BOLKOW	Landing	Landing	UK Reportable Accident: Nosewheel collapsed upon landing. Two POB, no injuries. Substantial damage to a/c. AAIB AARF Investigation.
201208024	05/07/2012	Accident	EVEKTOR AEROTECHNIK	Landing	Landing	UK Reportable Accident: During landing run the LH tyre burst, a/c veered of the runway and into a field. RH landing gear collapsed. Two POB, no injuries. AAIB AARF investigation.
201208274	21/07/2012	Accident	PIPER	Take-off	Initial climb	UK Reportable Accident: MAYDAY declared and forced landing in a field following engine failure. Two POB, no injuries. AAIB Field investigation.

201207399	01/07/2012	Accident	NAVION	Landing	Landing	UK Reportable Accident: Nosewheel would not fully extend. Confirmed from ground. A/c returned and landed nose gear up. Two POB no injuries. Propeller and nosewheel damaged. AAIB AARF investigation.
201208466	22/07/2012	Accident	ZENAIR	Approach	Approach	UK Reportable Accident. Engine failure on approach. Two POB, no injuries. A/c sustained extensive damage. AAIB AARF investigation.
201208620	21/07/2012	Accident	THRUSTER	Take-off	Take-off	UK Reportable Accident: A/c suffered engine power loss and landed in a field of tall crops. Two POB, no injuries. AAIB AARF investigation.
201208656	20/07/2012	Accident	CESSNA	Landing	Landing	UK Reportable Accident: Landing gear failed to extend. A/c made a slow approach, landed and spun around stopping faced backwards. Two POB, no injuries. A/c damaged. AAIB AARF Investigation.
201209458	21/07/2012	Accident	OTHER	Landing	Landing	UK Reportable Accident: A/c flying with landing gear down. On landing, RH gear collapsed, a/c remained on runway. Two POB no injuries. AAIB AARF Investigation.

201209790	14/08/2012	Accident	ROTARY	Take-off	Take-off	UK Reportable Accident. Engine failure on take-off at approx 50ft. Attempted to land on runway but sank and impacted ground. One POB, no injuries. Damage sustained. AAIB AARF investigation.
201209944	18/08/2012	Accident	PIPER	Landing	Landing	UK Reportable Accident: Landing gear partially collapsed after landing. One POB, no injuries. AAIB AARF investigation.
201209948	18/08/2012	Accident	CFM	Approach	Approach	UK Reportable Accident: Engine failure on final approach. A/c landed in field and nose wheel detached. One POB no injuries. AAIB AARF Investigation
201105281	18/05/2011	Accident	BEECH	Take-off	Initial climb	UK Reportable Accident: A/c crashed in a field shortly after take-off. Substantial damage. Two POB, no injuries. AAIB Field investigation.

201108354	17/07/2011	Accident	PIPER	Landing	Landing	UK Reportable Accident: Landing gear failed to deploy. PAN and fly-past inspection made. A/c made a forced landing.Two POB, no injuries. AAIB Field investigation.
201108411	21/07/2011	Serious incident	BOEING	Take-off	Take-off	Serious Incident: After take-off the crew declared an emergency due to nr2 engine fire. A/c diverted and landed without incident. 180 POB. Spanish CIAIAC are conducting a field investigation.
201108543	25/07/2011	Accident	CESSNA	Landing	Landing	UK Reportable Accident: RH undercarriage collapsed on landing. A/c spun around and came to rest overhanging the runway. Three POB, no injuries. AAIB Field investigation.
201108709	27/07/2011	Serious incident	SOCATA	Take-off	Initial climb	Serious Incident: After take-off thick smoke filled the cabin. MAYDAY declared and a/c diverted. Four POB, no injuries. AAIB Field investigation.
201108761	29/07/2011	Accident	PIPER	Take-off	Initial climb	UK Reportable Accident: A/c crashed into two houses following engine failure after take-off. Substantial damage. Two POB, one fatal, one serious injury. AAIB Field investigation.

201108961	31/07/2011	Accident	THRUSTER	Approach	Approach	UK Reportable Accident: Engine failure during approach. A/c overturned on subsequent forced landing. Substantial damage. Two POB, no injuries. AAIB AARF investigation.
201109709	18/08/2011	Serious incident	EMBRAER	Landing	Landing	Serious Incident: After landing crew were unable to turn the nosewheel. A/c disabled on the runway causing the airport to close for 30mins. A/c eventually towed from runway.
201110206	28/08/2011	Accident	HAWKER	Landing	Landing	UK Reportable Accident: A/c was observed to fly the approach and subsequent landing with the landing gear retracted. One POB, no injuries. AAIB AARF investigation.
201111222	15/09/2011	Accident	CFM	Landing	Landing	UK Reportable Accident: Pilot reported handling difficulties during flight and made a heavy landing. Two POB, no injuries. AAIB AARF investigation.
201111833	23/09/2011	Accident	OTHER	Take-off	En-route	UK Reportable Accident: MAYDAY declared just after take-off due to possible engine failure. A/c force landed in a field. One POB, a/c damage substantial. AAIB AARF investigation.

201111972	29/09/2011	Accident	OTHER	Landing	Landing	Engine caught fire during approach to land. A/c landed safely but a fire ensued and the a/c was destroyed. Delegated to the BGA.
201112168	30/08/2011	Accident	PIPER	Take-off	Take-off	UK Reportable Accident: Landing gear collapsed. One POB, no injuries. Lug on a/c fuselage damaged. AAIB AARF investigation.
201113197	22/10/2011	Accident	BEECH	Landing	Landing	UK Reportable Accident: A/c unable to retract gear & smoke in cockpit during initial climb. Gear retracted and smoke dissipated. Unable to extend gear. A/c made wheels up landing. Field investigation.
201114608	25/11/2011	Accident	ROCKWELL	Landing	Landing	UK Reportable Accident: A/c landed with nose landing gearretracted. One POB, no injuries. Damage to underside of fuselage and propeller tips. AAIB AARF investigation.

201115577	16/12/2011	Accident	PIPER	Landing	Landing	UK Reportable Accident: LH engine stopped on approach. Forced landing carried out in a field. Two POB, no injuries.AAIB Field investigation.
200802922	27/03/2008	Accident	SOCATA	Landing	Landing	UK Reportable Accident: NLG collapsed on landing. Substantial damage. No injury to one POB. AAIB Field investigation.
201200916	24/01/2012	Accident	CESSNA	Landing	Landing	UK Reportable Accident: When brakes applied on landing, a/c skidded off the runway. Two POB, no injuries. Damage tonose gear, propeller and wing tip. Subject to foreign Authority investigation.
201201304	05/02/2012	Accident	RANS	Take-off	Initial climb	UK Reportable Accident: Engine stopped during initial climb. A/c returned. Unable to reach chosen runway and landedheavily on secondary runway. Two POB, no injuries. AAIB AARF investigation.
201201585	15/02/2012	Serious incident	PIPER	Approach	Approach	UK Serious Incident: During approach, crew declared fire on board due to smoke in the cockpit. Three POB, no injuries. Electrical burning damage to a/c. AAIB AARF investigation.

200909980	12/09/2009	Accident	GROB	Landing	Landing	UK Reportable Accident: Rear a/c of three landing after flypast braked very hard to avoid hitting a/c in front. Both wing main boxes cracked. Two POB, no injuries. AAIB Field investigation.
200909980	12/09/2009	Accident				UK Reportable Accident: Rear a/c of three landing after flypast braked very hard to avoid hitting a/c in front. Both wing main boxes cracked. Two POB, no injuries. AAIB Field investigation.
200911634	22/10/2009	Accident	BRITTEN NORMAN	Approach	Approach	Reportable Accident: On approach, one engine failed. A/c lost altitude, ditched and sank. Ten POB, one with fatal injuries. Extensive a/c damage. Subject to foreign Authority investigation.
201014057	17/12/2010	Serious incident	AIRBUS	Approach	Approach	UK Serious Incident: Probe heat computer failure. Lost pitot heat and associated indications associated with this. MAYDAY declared and diversion initiated. AAIB AARF investigation.

201014547	22/06/2010	Accident	AVID	Landing	Landing	UK Reportable Accident: A/c ground looped on landing. TwoPOB, no injuries. AAIB AARF investigation.
201100238	09/01/2011	Accident	AVIONS ROBIN	Take-off	Take-off	UK Reportable Accident: A/c overran end of runway during take-off. Substantial damage. Three POB, no injuries. AAIBAARF investigation.
201100266	10/01/2011	Serious incident	AIRBUS	Landing	Landing	UK Serious Incident: Cross wind landing. Go-around initiated. A/c touched runway. Nr2 engine shut down due to reverser fault. MAYDAY declared. Diverted. AAIB Field investigation.

201101986	28/02/2011	Serious incident	EMBRAER	Landing	Landing	UK Serious Incident: PAN declared after a/c had landed due to an indication of smoke in the baggage hold. A/c stopped and evacuated. Fire service found no evidence of fire. AAIB AARF investigation.
201103624	09/04/2011	Accident	BAE	Landing	Landing	UK Reportable Accident: RH MLG tyres burst on landing dueto a failure within the RH landing gear. AAIB Field investigation.
201210378	23/08/2012	Accident	FOURNIER	Landing	Landing	UK Reportable Accident: Lowered landing gear which indicated locked down position. On touchdown the landing gear collapsed. One POB, no injuries. AAIB AARF investigation.

201210453	01/09/2012	Accident	THRUSTER	Landing	Landing	UK Reportable Accident: Intermittent engine failure during go-around. Forced landing. Two POB, one minor injuries. Extensive damage. AAIB AARF investigation.
201013279	25/11/2010	Serious incident	DE HAVILLAND	Approach	Approach	UK Serious Incident: Landing gear unsafe warning. Checklist actioned but only two 'Greens' illuminated. MAYDAY declared. Alternate system used. Landed safely. AAIB AARF investigation.
201202423	08/03/2012	Accident	BAE	Landing	Landing	UK Reportable Accident: A/c touched down and RH MLG collapsed. A/c skidded off the runway onto the grass. 14 POB, no injuries. AAIB Field investigation.
201205915	23/05/2012	Accident	JODEL	Take-off	Take-off	UK Reportable Accident: Engine failure on take-off, a/c crashed in farmland beyond the runway. Two POB, minor injuries. A/c extensively damaged. AAIB AARF investigation.

201210877	06/09/2012	Serious incident	PIPER	Landing	Landing	Damage to air intake. Engine failure after landing, whilst vacating runway the engine caught fire. Extinguished by RFFS. Two POB, no injuries.
201210963	08/09/2012	Accident	MOONEY	Landing	Landing	UK Reportable Accident: Landing gear failed to fully extend and subsequently collapsed on landing. One POB, no injuries. A/c substantially damaged. AAIB AARF investigation.
201206665	16/06/2012	Accident	ATR	Landing	Landing	UK Reportable Accident. Aircraft landed and LH main undercarriage collapsed, a/c slewed onto wingtip and slid for 150m. 43 POB, four minor injuries. AAIB Field investigation.
201207165	26/06/2012	Serious incident	ATR	Take-off	Initial climb	Serious Incident: MAYDAY declared and a/c returned following RH engine shut down. A/c landed, almost leaving the runway before coming to a halt. Hydraulic fluid found present on the runway.

201209971	12/08/2012	Accident	JABIRU	Take-off	Take-off	UK Reportable Accident: Landing gear collapsed shortly after the a/c landed. One POB no injuries. AAIB Field investigation.
201209977	20/08/2012	Accident	CESSNA	Landing	Landing	UK Reportable Accident: A/c struck a hedge on landing. Two POB, no injuries. A/c substantially damaged. AAIB AARF Investigation.
201210340	26/08/2012	Accident	OTHER	Approach	Approach	UK Reportable Accident: Nose pitched up violently while gliding into strip. A/c landed with gear only partially extended. Two POB, no injuries. AAIB Field investigation.

201204518	15/04/2012	Accident	OTHER	Take-off	Take-off	UK Reportable Accident: Engine failed after take-off and landed approximately 10m short of runway. Two POB no injuries. Damage to nosewheel and fork. AAIB AARF Investigation.
201205902	22/05/2012	Accident	RANS	Landing	Landing	UK Reportable Accident: On landing the a/c was caught by crosswind, nosewheel detached and a/c nosed over. One POB,no injuries. A/c damaged. AAIB AARF Investigation.
201205975	22/05/2012	Accident	OTHER	Landing	Landing	UK Reportable Accident: On landing, landing gear collapsed and one of the gear legs broke. One POB, no injuries. AAIB AARF investigation.
201209938	11/08/2012	Accident	OTHER	Landing	Landing	UK Reportable Accident. Glider landed, wheel brake handlepulled with no effect. A/c rolled off end of runway. One POB no injuries. Damage to landing gear and wing. Investigation delegated to BGA.
201211309	16/09/2012	Serious incident	HAWKER	Landing	Landing	Serious incident: LH underwing drop tank detached during landing. AAIB AARF investigation.

201211692	22/09/2012	Accident	BEECH	Landing	Landing	UK Reportable Accident: Nosewheel collapsed on landing. One POB no injuries. AAIB AARF Investigation.
201211889	28/09/2012	Accident	PIPER	Landing	Landing	UK Reportable Accident: Nosewheel collapsed on landing. Five POB, no injuries. AARF investigation.
201213189	27/10/2012	Accident	JODEL	Take-off	Initial climb	UK Reportable Accident: At 300ft after take-off, perspex landing light cover broken. Severe handling difficulties and a/c crashed. One POB, no injuries. AAIB AARF investigation.
201213231	31/10/2012	Accident	GROB	Landing	Landing	UK Reportable Accident. Engine failed on landing causing a hard landing on grass at low speed. Two POB no injuries. Investigation delegated to BGA.

201213248	30/10/2012	Accident	TITAN	Landing	Landing	UK Reportable Accident: Throttle jammed, landing gear would not deploy. Wheels up landing. Two POB, no injuries. AAIB AARF Investigation.
201213507	03/11/2012	Accident	PIPER	Approach	Final approach	UK Reportable Accident: A/c landed in a field after suffering landing gear problems on approach. Two POB, no injuries. AAIB AARF investigation.
201213917	29/09/2012	Accident	ZENAIR	Landing	Landing roll	UK Reportable Accident: Rudder bar snapped after landing roll and a/c made a 180deg turn. One POB, no injuries.
201214173	14/11/2012	Accident	OTHER	Landing	Landing	UK Reportable Accident: Engine began running abnormally. A/c nosed over on landing. Two POB, one with minor injuries. AAIB AARF investigation.

201215152	17/12/2012	Accident	OTHER	Landing	Landing	UK Reportable Accident: After flypast inspection due to unsafe gear indication, undercarriage collapsed on landing. Two POB, no injuries. AAIB AARF investigation.
201215223	18/12/2012	Accident	CESSNA	Landing	Landing	UK Reportable Accident: Nose wheel failed to lower. One POB, no injuries. A/c substantially damaged. AAIB AARF investigation.
201215266	16/12/2012	Accident	CESSNA	Landing	Landing	UK Reportable Accident: After several go-arounds due to landing gear malfunctioning, the a/c made a wheels-up landing. One POB, no injuries. AAIB AARF investigation.
201215703	27/12/2012	Serious incident	BOEING	Take-off	Initial climb	Serious Incident: A/c returned with engine vibrations and high EGT. On landing, engine damage was evident, engine still running. AAIB AARF investigation.
201215728	20/12/2012	Serious incident	BAE	Landing	Landing	Serious incident: Nr4 engine in flight shut down during landing, suspected damage to the engine turbine.

201300166	09/01/2013	Accident	GROB	Take-off	Initial climb	UK Reportable Accident: Aircraft made a forced landing in a field following propeller failure. Two POB, no injuries. AAIB Field investigation.
201301635	15/02/2013	Accident	PIPER	Take-off	Initial climb	UK Reportable Accident: First take-off rejected. During second attempt, engine failed and a/c came to rest, approximately 50m from runway threshold. One POB, no injuries. AAIB AARF investigation.
201303769	06/04/2013	Accident	JODEL	Landing	Landing roll	UK Reportable Accident. Engine stopped. Forced landing made into field. Two POB, no injuries. AAIB AARF investigation.
201303773	06/04/2013	Accident	FLIGHT DESIGN	Landing	Landing	UK Reportable Accident: Aircraft nosed over on landing and came to rest inverted. Two POB, one serious injuries and one minor injuries. AAIB AARF investigation.
201303903	06/04/2013	Accident	OTHER	Approach	Approach	UK Reportable Accident: Forced landing due to engine failure. A/c landed in a field next to the airstrip. One POB, no injuries. AAIB AARF investigation.

201304817	03/05/2013	Serious incident	BAE	Take-off	Initial climb	Serious incident: Temporary loss of power on both engines during initial climb out. No damage or injuries were reported. Subject to Foreign Authorities investigation.
201305012	03/05/2013	Accident	SHORT	Landing	Landing roll	UK Reportable Accident: Nosewheel and yoke assembly detached during landing. Four POB, no injuries. AAIB AARF investigation.
201305238	12/05/2013	Serious incident	PERCIVAL	Take-off	Take-off	Serious Incident: A/c lost tail wheel on departure from runway. Full emergency landing was performed with no further incident. One POB, no injuries. AAIB AARF investigation
201305774	18/05/2013	Accident	OTHER	Take-off	Initial climb	UK Reportable Accident: A/c suffered engine problems after take-off and made a forced landing in a field. Two POB, no injuries. AAIB AARF investigation.
201305988	26/05/2013	Accident	SLINGSBY	Take-off	Take-off	UK Reportable Accident: A/c lost nose wheel during take-off and diverted. Two POB, no injuries. AAIB AARF investigation.

201306058	18/05/2013	Accident	PIPER	Take-off	Initial climb	UK Reportable Accident: A/c suffered engine failure after take-off and landed in a field. One POB, no injuries. AAIB AARF investigation.
201306983	16/06/2013	Accident	ZENAIR	Approach	Final approach	UK Reportable Accident: Engine failed, landed short of landing strip. Two POB, no injuries.
201307218	19/06/2013	Accident	AEROSPATIALE	Landing	Landing	UK Reportable Accident: The pilot lost yaw control of the helicopter as it approached the final stage of a decelerating transition to a hover. Two POB, one serious injuries. AAIB Field investigation.
201308176	07/07/2013	Accident	SOCATA	Landing	Landing	UK Reportable Accident: LH gear collapsed on landing. Three POB, no injuries reported. AAIB AARF investigation.

201308639	14/07/2013	Accident	MAINAIR	Landing	Landing	UK Reportable Accident: Aircraft damaged during forced landing following engine failure. One POB, minor injuries. AAIB AARF investigation.
201309087	19/07/2013	Accident	OTHER	Landing	Landing	UK Reportable Accident: Aircraft landed wheels-up because the gear electric actuator fuse had blown. One POB, no injuries. AAIB AARF investigation.
201309466	26/07/2013	Accident	KOLB	Landing	Landing	UK Reportable Accident: Forced landing in field following propeller detachment. One POB, no injuries. AAIB AARF investigation.
201309605	02/08/2013	Serious incident	BOEING	Take-off	Initial climb	Serious Incident: Aircraft suffered multiple electrical system failures after take-off and returned safely to departure airport. 124 POB, no injuries. Subject to AAIB Field investigation.
201309877	01/08/2013	Accident	FOURNIER	Landing	Landing roll	UK Reportable Accident: Aircraft landing gear collapsed during landing. One POB, no injuries. AAIB AARF investigation.

201309946	06/08/2013	Accident	VANS	Approach	Circuit pattern - downwind	UK Reportable Accident: Engine failure. Aircraft inverted after making a forced landing in a field. One POB, minor injuries. AAIB AARF investigation.
201310025	27/07/2013	Accident	KOLB	Take-off	Initial climb	UK Reportable Accident: Engine failure after take-off, resulted in a forced landing causing damage to aircraft. One POB, no injuries. AAIB AARF investigation.
201310184	09/08/2013	Accident	CYCLONE AIRSPORTS	Take-off	Initial climb	UK Reportable Accident: Power loss after take-off. During forced landing, aircraft stalled and nose dropped. Aircraft hit the ground, collapsing the NLG. Two POB, one minor injuries. AAIB AARF investigation.

201310340	12/08/2013	Accident	DE HAVILLAND	Landing	Landing	UK Reportable Accident: Forced landing due to engine problems. Two POB, serious injuries. AAIB AARF investigation.
201310418	17/08/2013	Serious incident	BOEING	Approach	Missed approach or go-around	Serious Incident: Aircraft experienced flap/slat problems following a go-around and diverted. MAYDAY declared due to low fuel status. Aircraft landed safely. Subject to AAIB Field investigation.
201310868	28/08/2013	Accident	RANS	Take-off	Initial climb	UK Reportable Accident: Aircraft's engine faltered. Aircraft then entered a stall and vertical dive. One POB, fatally injured. AAIB Field investigation.
201311258	27/08/2013	Accident	OTHER	Landing	Emergency landing or off-runway landing	UK Reportable Accident: Aircraft damaged during forced landing due to power loss. Two POB, no injuries. AAIB AARF investigation.

201311457	31/08/2013	Accident	PIPER	Approach	Final approach	UK Reportable Accident: Impact with ground obstacle following loss of power on approach. One POB, minor injuries. AAIB AARF investigation.
201312247	24/09/2013	Serious incident	BAE	Approach	Missed approach or go-around	Serious Incident: During go-around, total EFIS (Electronic Flight Instrument System) and VHF comms failure. Aircraft returned. AAIB AARF investigation.

201312506	23/09/2013	Serious incident	SOCATA	Landing	Landing: Other	Serious Incident: Engine fire on landing. Two POB, no injuries. AAIB AARF investigation.
201312846	04/10/2013	Accident	OTHER	Take-off	Take-off	UK Reportable Accident: Engine failure after take-off. Landing gear damaged during forced landing. One POB, no injuries. AAIB AARF investigation.

201312863	04/10/2013	Accident	BELL	Landing	Emergency landing or off-runway landing	UK Reportable Accident: Engine failure. During the ensuing forced landing the helicopter rolled over, coming to rest on its side. One POB, minor injuries. AAIB Field investigation.
201313809	24/10/2013	Accident	PIPER	Landing	Landing	UK Reportable Accident: The aircraft overran the end of the runway, travelled through a fence and across a road, before coming to rest in a field. One POB, no injuries. AAIB AARF investigation.

201314113	03/11/2013	Serious incident	AIRBUS	Take-off	Initial climb	Serious Incident: Smoke fumes in flight deck and cabin. Subject to ANSV investigation.
201403951	27/03/2014	Serious incident	AIRBUS	Take-off	Climb into traffic pattern	Serious Incident: After departure, nr3 engine failed. Aircraft returned to land after fuel jettison. 482 POB, no injuries. Subject to Foreign Authority investigation.
201404046	31/03/2014	Accident	VANS	Take-off	Initial climb	UK Reportable Accident: Engine stopped. Aircraft returned. Aircraft struck the ground with a high sink rate, extensively damaged. One POB, minor injuries. AAIB AARF investigation.
201404590	15/04/2014	Accident	AVIONS ROBIN	Landing	Emergency landing or off-runway landing	UK Reportable Accident: Forced landing in field due to engine problem. Three POB no injuries. Aircraft damaged. Subject to AAIB AARF investigation.
201404602	11/04/2014	Accident	FLY BUY ULTRALIGHTS	Approach	Approach	UK Reportable Accident: Aircraft stalled on approach after engine was shut down due to the throttle sticking open. One POB, no injuries reported. Subject to AAIB AARF investigation.

201405242	23/04/2014	Accident	CESSNA	Landing	Landing	Foreign Accident: Left main gear collapsed on landing. Damage to left main gear and propeller. One POB, no injuries. Subject to AAIB AARF investigation.
201406082	31/01/2014	Accident	PIAGGIO	Landing	Landing	Foreign Accident: Landing gear collapsed during landing rollout. 5 POB, no injuries. NTSB investigation.
201407396	05/06/2014	Accident	PIPER	Take-off	Take-off: Other	UK Reportable Accident: Tow plane had engine failure. Glider struck tree following emergency landing. Two POB, no injuries reported. Aircraft substantially damaged. Investigation referred to the BGA.
201407396	05/06/2014	Accident	SCHLEICHER	Take-off	Take-off - aircraft tow: Other	UK Reportable Accident: Tow plane had engine failure. Glider struck tree following emergency landing. Two POB, no injuries reported. Aircraft substantially damaged. Investigation referred to the BGA.
201408199	21/06/2014	Accident	BEECH	Landing	Landing	UK Reportable Accident: LH landing gear collapsed on landing. Damage to underside of fuselage. Three POB, no injuries reported. Subject to AAIB AARF investigation.
201408214	21/06/2014	Accident	CESSNA	Take-off	Take-off	Foreign Accident: Aircraft suffered a power loss after take-off, forced landing carried out. Aircraft substantially damaged. Five POB, no injuries reported. Subject to AAIU investigation.
201409448	14/07/2014	Accident	PIPER	Landing	Landing	UK Reportable Accident: Nose gear would not fully extend. Two POB, no injuries. Aircraft damaged. AAIB AARF investigation.
201409505	10/07/2014	Accident	CASA	Landing	Landing	UK Reportable Accident: LH landing gear failed on landing. One POB, no injuries reported. Subject to AAIB AARF investigation.
201409815	21/07/2014	Accident	PIPER	Take-off	Initial climb	UK Reportable Accident: Aircraft suffered engine failure after take-off. Three POB, no injuries reported. Damage to be assessed. Subject to AAIB AARF investigation.

Narrative text
AAIB Bulletin 5/2005, ref: EW/C2004/03/04 - Summary: Shortly after take off, at approximately 300 feet, the pilot heard a whining noise which was followed by a bang. The pilot realised that something serious had occurred and landedimmediately. Initial inspection revealed that the tail rotor and its control system remained intact but its drive system was no longer functional. The loss of tail rotor drive was the result of the rotating driveshaft coming into contact with the titanium tunnel through which it passed. The lower attachment of the rear left brace assembly securing the main rotor gearbox to the aircraft structure had failed and this allowed greater than normal displacement of the upper end of the gearbox under load. This permitted sufficient misalignment of both the tail rotor driveshaft and the engine output shafts to bring the former and one of the latter into contact. The failure of the rear left brace assembly took the form of fracture of the four bolts connecting the steel attachment bracket to the aircraft structure. The evidence is consistent with incorrect torque tightening of the bolts of the failed joint at manufacture ofthe aircraft. The installed bolt tension is of critical importance to the integrity of attachment between the lowerbrackets of the brace assemblies and the cabin
AAIB Bulletin 5/2004, ref: EW/G2004/01/03 - Summary: The aircraft suffered an engine failure shortly after take off. The terrain ahead of the aircraft was inhospitable but the pilot managed to find a small area of open ground into which to carry out a forced landing. The aircraft was damaged in the landing but there was no injury to the pilot. During a subsequent examination of the engine it was found that the turbine wheel within the turbocharger unit was 'stiff' when an attempt was made to turn it by hand. The unit was sent to an overhaul agency, who's inspection report disclosed that no mechanical damage had occurred to the internal components and that the nut on the turbine/compressor shaft was correctly torqued. However, a considerable build up of carbon deposits was noted between the turbine wheel and the seal area of the bearing housing. This had clearly resulted in interference and consequent restriction of the rotating assembly, resulting in an effective obstruction of both the inlet and exhaust manifolds. This in turnwould cause an increased exhaust backpressure together with a loss of inlet manifold pressure, leading to a loss ofengine power. The turbocharger was installed in the aircraft, with the engine, in August 2001, since when it had accumulated 275 operating hours. The unit was an 'exchange' item and was presumably

AAIB Bulletin 4/2004, ref: EW/C2004/01/01 - Summary: After take off, at around 1,000 feet, the pilot felt a kick tothe left followed by an abnormal vibration. He decided tocarry out a precautionary landing and landed successfullyback on the helipad. On the ground the pilot shutdown andobserved, as the blades slowed, a misalignment of the tail rotor driveshaft. Examination of the tail rotor driveshaft showed that the rubber bush from the nr4 bearing was damaged and, having been released from its location, had migrated aft, although it had remained attached. The bearingsand rubber inserts are maintained 'on-condition' and there is no requirement to remove the tail rotor driveshaft toinspect these components. This particular helicopter was over 20 years old and the rubber bushes were most likely those fitted during manufacture. Examination showed that the nr4 bearing, although filled with grease, was heavily contaminated with elastomer particles from the rubber bush. The bush had become swollen from prolonged contact with grease; this had resulted in wear of the bush due to contactwith the block whilst the bush was rotating, thus contaminating the grease with the associated wear products. CAA Closure: The hazard is acceptable provided the frequency of
See also 200400683.
During the take-off roll the flight deck door opened, which the SCCM later attempted to close but was unable to secure in the closed position. The flight continued with the door in the open position. The reporter notes the closing door locking lever resulted in no appreciable shoot bolt extension. During engineering investigation, the flight deck door lower hinge bracket (p/n: 89-03-10065) was replacedand following adjustments, door lock operation was satisfactory. It is understood that no further instances have occurred. CAA Closure: The hazard is acceptable provided the frequency remains low.
AAIB Bulletin 1/2005, ref: EW/C2004/04/01 - Summary: After take off the pilot was unable to raise the landing gear and was presented with failure indications affecting both the lift dump and anti skid systems. Following a successful landing at Farnborough, and discussions with the aircraft's maintenance organisation, the aircraft was flown to Blackbushe for further technical investigation. After landing on Runway 26 the aircraft left the runway, struck a series of obstructions and was destroyed: there was no fire and the pilot was uninjured. The support bracket for the right main landing gear weight-on-wheels switch was found to have sustained a pre-impact failure which accounted for the indications reported by the pilot. Five Safety Recommendations (2004-95 to -99) have been made to the aircraft manufacturer as a result of this investigation. CAA Closure:CAA FACTOR F4/2005 was issued on 14 February 2005.

AAIB Bulletin 6/2004, ref: EW/G2004/04/10 - Summary: The student pilot was carrying out circuits to Runway 22 on his fourth solo flight. During the climbout from a 'touch and go' landing, at about 400 feet aal, the engine began to run unevenly and ATC advised the pilot that they could seesmoke coming from the aircraft. ATC cleared the aircraft to continue in the circuit and advised that it was "numberone to land". After what appeared to be a normal landing but to the right of the centreline, in benign weather conditions, the aircraft moved further to the right and departed the runway, at speed, onto Taxiway C. It then veered left off the taxiway onto a grass area and stopped. There was no fire and the pilot was uninjured. In the course of the landing roll the left main landing gear had been damaged. The pilot stated that he had tried to increase power during the circuit but without success. During the landing heleft the power lever partly open and following the touchdown he reported that the aircraft suddenly accelerated. Asthe pilot was attempting to stop the aircraft safely he applied more pressure on the right brake than the left and the aircraft vacated the runway onto the taxiway, which was the normal exit point after a landing, and then onto thegrass verge, where it stopped. The pilot shut the aircraft down, returning the power lever to the idle position as he did
The pilot reported that he was returning from a local flight conducted in very good flying conditions. At the startof the downwind leg he ran through the checks and loweredthe single wheel landing gear, checking that it was in the down and locked position. Touchdown was smooth, but the landing gear did not prevent the fuselage from contacting the ground, causing damage to the propeller, scraping of the fuselage and possible shock load damage to the engine. The aircraft is fitted with a single central landing wheel, which is extended and retracted manually by means of a hand operated lever welded to a cross tube. The landing gear is locked either up or down by a latch which is manuallyreleased but engages automatically when the cross tube, and thus the landing wheel, is in the fully extended or fully retracted position. The maintenance organisation advised that a crack had been found at the base of the lever, and that it had separated from the rest of the assembly whenthe aircraft was recovered. Examination of the crack by the maintenance organisation showed that although the finalfracture was new, there was evidence that some of the crack was old damage. It was surmised that the crack had beengrowing, so that when the pilot moved the lever to the extended position, the lever moved without fully extending the gear or engaging the downlock latch. The landing gear

Following a normal touchdown, after rolling approximately70% of the runway distance, 'slight to moderate braking was applied'. Without warning the right main landing gear (MLG) collapsed and the aircraft veered through 90deg to the right before coming to rest close to the edge of the runway. It was found that the right MLG oleo strut had fractured close to its lower end, allowing the wheel and half fork assembly to break away. The oleo strut is attached to the fork by means of a bolt located in a fore-aft directionacross the diameter and it was apparent that the plane ofthe fracture passed through the forward bolt hole and just above the aft hole. The components were subjected to a metallurgical examination, which showed that the failure had resulted from a fatigue mechanism originating at the forward bolt hole. Inspection of the bore revealed that the surface finish was very poor as a result of 'abusive machining' that had occurred during drilling of the hole. The effect of this would have been to considerably reduce the fatigue resistance of the component. The surface finish of the aft bolt hole was similarly poor, although no fatigue cracks were evident. In the absence of any evidence of abnormal loading, it was concluded that the failure of the strut resulted from long-term service loads acting on a component with considerably reduced fatigue resistance due

AAIB Bulletin 7/2004, ref: EW/C2004/01/06 - Summary: On arrival at Alderney the pilot flew a normal 90kt visual approach to Runway 26 with the landing gear indicating down and locked. The pilot estimated there to be a strong surface wind of 200deg/20-30kt, so he used the 'wing down' technique to cater for the crosswind. After touchdown the aircraft started to veer to the right necessitating the use of left rudder and brake to correct for this. The nose of theaircraft then lowered, allowing the propeller to come into contact with the tarmac, and the aircraft came to rest approximately 200 metres into the runway. The aerodrome weather report for 0750 hrs gave the surface wind as 200deg/21kt gusting to 33kt and a strong wind warning for Force 6 southerly winds was issued at 0725 hrs. The aircraft has ademonstrated crosswind limit of 17kt. Examination of the aircraft showed that the nose landing gear actuator attachment feet, which are part of the engine mount, had fractured allowing the nose landing gear to collapse. The feet consist of short steel tubes welded to the mount. One of thefeet showed evidence of cracking and the surface of the crack was corroded, suggesting that it was old damage. The remaining fracture surfaces were clean and bright. Piper Service Bulletin 1103B, issued on 25 November 2003, included an additional check on an existing requirement

AAIB Bulletin 9/2004, ref: EW/G2004/06/10 - Summary: At approximately 1,200 feet agl, the engine suddenly stopped and would not crank over when the pilot attempted a re-start. During the subsequent forced landing, the aircraft became lodged in a tree some 30 to 40 feet above the ground. The pilot, who suffered only minor injuries, was assisted to the ground by a local householder who provided a ladder.An examination of the engine by a PFA inspector revealed some evidence that the engine had become overheated and seized. The pilot later commented that the stick forces werehigher and glide performance of the aircraft worse than when he had practised power failure with the engine at idleRPM.
CAA Closure: The hazard is acceptable provided the frequency of occurrence remains low.

AAIB Bulletin 2/2005, ref: EW/G2004/06/25 - Summary: A normal approach to Runway 26 was carried out with a wind of 6kt. from 330deg. The three green landing gear 'Down and Locked' indicator lights were illuminated and approximately2 miles from touchdown full flap was selected and visually confirmed. The touchdown was smooth but during the landing run the 'Gear Unsafe' warning horn sounded. The pilot looked down and noticed that the left main landing gear 'Down and Locked' green indicator light had extinguished and the red 'Gear Unsafe' indicator light had illuminated. Both the right main and nose landing gear 'Down and Locked' green indicator lights were illuminated. The left main landing gear collapsed and the aircraft slewed to the left before coming to rest. The pilot carried out the emergency shutdown drills and the aircraft was vacated without injury.The left landing gear was examined by a metallurgist who found that all the failures were caused by a one time overload force with no evidence of fatigue, corrosion or manufacturing defect. The pilot/owner assessed that a possible cause may have been that the left main landing gear was slightly out-of-rig which allowed the side brace to unlock when running over a bump in the runway.
CAA Closure: No CAA action appropriate.

AAIB Bulletin 10/2004, ref: EW/G2004/06/17 - Summary: Theaircraft was carrying out solo stop-and-go circuits to Runway 27 as part of a night qualification exercise at Liverpool airport. As it touched down at the conclusion of its second circuit, ATC observed sparks from the aircraft and initiated aircraft accident procedures. The aircraft came to rest on the runway with the landing gear collapsed, damage to its propeller, engine and underside. The pilot was able to vacate the aircraft without assistance.
CAA Closure: No CAA action appropriate.

AAIB Bulletin 11/2005, ref: EW/C2004/06/02 - Summary: Shortly after take off, with the pilot and five parachutists on board (including one 'tandem' pair), the aircraft's engine began to lose power. The pilot flew to the east away from the airfield for a distance of some 6nm, achieving a maximum height of approximately 1,100ft agl, before turningback. As the engine lost power the pilot was unable to maintain height and, in attempting a forced landing, the aircraft clipped the tops of several tall trees and crashed steeply nose down into a sloping grass field. Nine Safety Recommendations (2005-040 to -045 and 2005-060 to -062) aremade.
CAA Closure: CAA FACTOR F40/2005, detailing the CAA responses to the nine AAIB Safety Recommendations, was issued on 9 December 2005. Any further CAA action required will be progressed via the 'Annual Review of AAIB Recommendations' procedure.

AAIB Bulletin 5/2005, ref: EW/G2004/06/22 - Summary: During climb out, following a touch-and-go, the engine stoppedabruptly and a forced landing was carried out. Both occupants exited the aircraft without difficulty. The engine, aSimonini Victor 2 two stroke, twin cylinder, twin ignition, water-cooled engine, was examined and two burn holes were observed in the side wall of the rear cylinder head. The plating on the top end of the inner walls of both cylinders was cracked and partially detached in places. Metallurgical examination of the engine bearings revealed long term corrosion within the roller bearing, which had occurred whilst the engine was stationary. It was considered that the engine failure was caused by the loss of coolant to theengine allowing hot gases to burn through the cylinder casing. The accumulation of liquid in the crankcase had probably resulted from a leak past one or both of the cylinderhead elastomeric seals. The engine had completed a total of 6 hours 45 minutes since 2003 at the time of the enginefailure.
CAA Closure: The hazard is acceptable provided the frequency of occurrence remains low.

AAIB Bulletin 10/2004, ref: EW/G2004/06/23 - Summary: After take off and selection of gear 'Up', a gear unsafe warning occurred. The landing gear was selected 'Down' but thenose landing gear continued to indicate an unsafe condition. An attempt was made to lock the nose landing gear downby carrying out a touch and go on the main landing gear only. However, during the touch and go the pilot was unableto prevent the aircraft from pitching nose down, causing the unlocked nose landing gear to collapse and the propellers to strike the grass runway surface. Examination of thenose landing gear assembly showed that a failed bracket had allowed the upper end of the nose landing gear leg to leave a guide track, making it impossible for the leg to belocked in either the down or up position.
CAA Closure: The hazard is acceptable provided the frequency of occurrence remains low.

See also 200400166.
AAIB Bulletin 6/2005, ref: EW/C2004/02/02 - Summary: The aircraft departed from Kilimanjaro en route to London (Luton) airport with a known hydraulic problem. The crew believed, incorrectly, that this was allowed under the terms ofthe Minimum Equipment List. During the approach at Luton the crew were unable to obtain indications that the gear was down and locked following selections on both the normaland emergency systems. The crew requested a diversion to Stansted and the aircraft was configured for a full flap landing on Runway 05. During the landing roll the right main landing gear partially retracted and the aircraft veeredto the right until it finally left the paved surface, crossed the grass, and came to rest about 139 metres to the right of the runway centreline. Four safety recommendations(2005-023 to -026) have been made as a result of the investigation. CAA Closure: CAA FACTOR F26/2005, detailing the CAA responses to the four AAIB Safety Recommendations, was issued on 7 July 2005. Any further CAA action required will be progressed via the 'Annual Review of AAIB Recommendations' procedure.
AAIB Bulletin 6/2005, ref: EW/C2004/02/06 - Summary: On the day of the accident the aircraft was flown to a maintenance organisation, for the rectification of a landing gearretraction problem, with the landing gear extended and the electric circuit breaker for the electrical hydraulic pump 'pulled'. The accident flight to the grass airfield where the maintenance organisation was based was uneventful. On final approach the speed was reduced to 75 mph and 30° of flap selected with the landing flare being carried out at 65 mph. The pilot assessed the aircraft's touchdown as 'a greaser' and held the nose wheel off the ground as longas possible. As the aircraft decelerated the nose droppedand the propeller struck the ground. The nose landing gear pivots were badly worn, the overcentre downlock was out of adjustment, the breakout force virtually non existent, and with the electrical hydraulic pump switched off there was no residual hydraulic pressure in the down lines and the landing was on a grass airfield. Both main landing geardownlock latch pivot pins had double fatigue and the leftone had failed which was the reason for the original landing gear problem. The investigation report issued by the AAIB contains two Safety Recommendations (2005-32 and 2005-56), both of which are addressed to the aircraft manufacturer. See also AAIB Bulletin 10/2005, which contains

AAIB Bulletin 10/2004, ref: EW/G2004/02/07 - Summary: Theaircraft took off from Runway 24 and suffered a fluctuating loss of engine power necessitating a forced landing. The aircraft was turned back towards the airfield to land downwind on the down sloping wet grass surface of Runway 36.The aircraft bounced and overran the runway colliding with a runway stop end marker board. The nose landing gear collapsed causing the aircraft to pitch forward and come to rest inverted. Both occupants vacated the aircraft uninjured. The loss of power was probably due to carbon deposits in one cylinder causing the exhaust valve to stick. CAA Closure: No CAA action appropriate.
AAIB Bulletin 4/2005, ref: EW/C2004/02/03 - Summary: The left main landing gear (MLG) began a violent shimmy (yaw oscillation) when the wheelbrakes were applied after a normal landing touchdown, probably damaging the MLG lower torsion link. The shimmying stopped when braking was reduced but restarted when braking was increased, causing the torsion link to fracture. Further higher amplitude shimmying ofthe left MLG ensued, resulting in severe MLG tyre, wheel and brake damage and substantial oscillatory loads on the aircraft structure. Steering difficulties were experiencedduring both shimmying episodes. It was likely that the shimmying resulted from excessive wear of the torsion link apex joint that reduced the effectiveness of the shimmy damper. Maintenance records indicated that the MLG had been maintained in accordance with the manufacturer's recommendations, but it was considered that relevant Aircraft Maintenance Manual (AMM) procedures could be difficult to follow. Similar failures had occurred over a number of years, which had been attributed by the aircraft manufacturer to excessive apex joint wear that had not been detected or adequately rectified during maintenance. The investigation report issued by the AAIB contains one Safety Recommendation (2004-103), which is addressed to the FAA and
After take off, on landing gear retraction, the green 'down' lights extinguished but the 'transit/unlocked' light remained illuminated. The aircraft was positioned downwind and the landing gear was extended, resulting in only the two MLG green lights illuminating. After a flypast inspection, ATC confirmed that the two main wheels appeared to be down and locked but that the NLG was only partially extended. The aircraft climbed to 2000ft while the pilot's operating handbook was consulted and emergency checklist actioned. The problem could not be rectified and a second flypast inspection confirmed that the NLG still appeared unlocked. The pilot declared an emergency and, after consultationwith engineers, elected to make an approach to asphalt Runway 26 at Kemble, which has a landing distance available of 1,594 metres. Shortly after landing, the NLG collapsed and the aircraft skidded for 130 metres before stopping. Both the pilot and passenger were able to vacate the aircraft without injury. Engineering investigation revealed thatthe non-rechargeable compressed gas struts, used in the emergency lowering system, did not contain enough pressure to fully lock the NLG down. It was also discovered that the brushes on the generator were worn to the extent that their condition probably rendered the hydraulic system inoperable. The TB20

AAIB Bulletin 12/2004, ref: EW/G2004/08/10 - Summary: During the landing phase the nose wheel of the aircraft detached and bounced up into the propeller causing damage. The design of the nose wheel bearing was changed following a number of previous failures but this aircraft had not been fitted with the modified bearing. The pilot considered that a period of taxiing with a seized bearing had resulted in excessive heat build up which in turn led to the failureof the bonding between the glass/metal joint of the nosewheel assembly. CAA Closure: The hazard is acceptable provided the frequency of occurrence remains low.
NLG Torque link centre pivot attaching pin failed. An existing crack through the threaded portion had subsequently completely failed. The failure is being reviewed by both the AAIB, and BEA, no further CAA action is considered necessary. BEA report due end Jan 05. CAA Closure: The hazardis adequately controlled by the action stated above.
Engine manufacturer advised. See also 200205746.
Aircraft on its belly with the landing gear collapsed.
AAIB Bulletin 12/2004, ref: EW/G2004/09/02 - Summary: During take off, the left main landing gear lower torque linkpivot bolt failed, resulting in the complete detachment of the wheel and inner cylinder of the oleo assembly. The aircraft was damaged during the subsequent landing. The investigation revealed that the torque link pivot bolt had suffered a fatigue failure and was generally in a poor condition. This failure was similar to one that occurred recently to another PA28-161 (G-BTBC; AAIB Bulletin 9/2004; occurrence no. 200307475), following which safety recommendations were made to EASA and the FAA calling for improved inspection procedures. At the time of writing, no response has been received from EASA to these recommendations; the FAA are in the process of considering their response. CAA Closure: The hazard is adequately controlled by the actionsstated above.

AAIB Bulletin 2/2005, ref: EW/G2004/09/07 - Summary: During the take off from Glasgow Airport, the left inboard (No.2) tyre shed its tread. This led to the loss of the 'A' system hydraulic contents, failure of the landing gear to retract and failure of the left main landing gear (MLG) green 'down and locked' light to illuminate in the cockpit. After holding for three hours to burn off fuel, the aircraft landed safely. The tyre failure was most probably due tofatigue in the sidewall. The tyre was at its sixth retread and close to its wear limit and may have reached its ultimate fatigue life prematurely for an undetermined reason;the retread limit for this tyre was R-6. The operator hassince put in place several safety actions to prevent recurrence. No recommendations are made in this report.

CAA Closure: The hazard is adequately controlled by the actionsstated above.

AAIB Bulletin 9/2005, ref: EW/C2004/09/02 - Summary: At approximately 75kt on take off from Runway 05 at Stansted the aircraft deviated to the right but was recovered to thecentreline by a reduction in power and use of rudder. When power was re-applied to continue the take off the aircraft turned significantly to the left and the take off was abandoned. As the aircraft came to a stop external indications led the commander to believe that the left engine was on fire. The Airfield Fire and Rescue Service attended thescene and the left engine was successfully shutdown without further incident. Subsequent examination revealed that the left engine turbine had burnt out as a result of the left propeller being hung on the flight fine pitch stop at the time the throttle was re-opened. Furthermore, a defectwas discovered in the Nose Wheel Steering (NWS) follow-upcontrol valve that caused vibration of the NWS and damaged the dowel pins in the steering gearbox leading to erratic changes in the NWS datum making the aircraft difficult to steer.

CAA Closure: The hazard is acceptable provided the frequency of occurrence remains low.

On the day of the accident, the pilot had flown from Gloucester to Tilstock without incident. After starting up forthe return flight, the engine reportedly "staggered" whenthe throttle was opened. This was unusual and the pilot therefore spent some time running up the engine and carrying out magneto and power checks. After satisfying himself that the engine was running normally and delivering full power, he took off from Tilstock and flew to Gloucester without further incident. The weather at Gloucester was good, with a gusty wind from the north/north-west. Anticipating a strong wind on the approach, the pilot turned slightly in towards runway 36 whilst on base leg to compensate; however, the headwind did not materialise as expected. The aircraft, which was relatively light, was thus a little high and a power reduction to almost idle was required to correct the altitude. Having turned on to final approach, a strong gust of wind from the left was encountered and the pilot applied left aileron to compensate, after which the aircraft intercepted the correct glideslope. The throttle wasthen eased forward but the engine failed to respond. Suspecting fuel starvation, the pilot selected the electric fuel pump to the 'emergency' setting and moved the throttle again but the engine still failed to respond. A higher than intended rate of descent developed and the aircraft touched down in a field

AAIB Bulletin 11/2006, ref: EW/C2004/10/03 - Summary: Shortly after take off, the aircraft suffered an engine malfunction and the pilot attempted to return to the airfield. During the turn, the aircraft appeared to stall and impacted the ground in a nose low attitude, fatally injuring thepilot. A defect was discovered within the engine's dual magneto, which had recently been refitted following a 500 hour inspection, affecting both ignition systems. This led to a loss of power, accompanied by misfiring, that was consistent with aural evidence from witnesses. Issues concerning quality control of maintenance activities and maintenance data were identified during the investigation. Four safety recommendations (2006-028 to -031) were made. See also AAIB Bulletin 12/2006, which contains a correction to the original report, whereby Safety Recommendation 2006-029 is withdrawn and replaced by 2006-134.
CAA Closure: CAA FACTOR F42/2006, detailing the CAA responses to the four AAIB Safety Recommendations, was issued on 11 January 2007. Any further CAA action required will be progressed via the'Annual Review of AAIB Recommendations' procedure.

AAIB Bulletin 2/2005, ref: EW/G2004/10/06 - Summary: The aircraft, which had been parked outside for two months with each fuel tank less than three-quarters full, was subjected to a thorough pre-flight inspection that included the taking of fuel samples to check for water contamination. Shortly after departure the aircraft suffered a power loss necessitating a forced landing during which the nose landing gear collapsed. Subsequent examination of the fuel system revealed significant amounts of water in the fuel tanks, carburettor bowl, electric fuel pump filter and the fuellines aft of the firewall. No water was evident from the four drains; one in each fuel tank and one in each sump tank.

AAIB Bulletin 2/2009 contains an addendum to the original report, which states that, during a subsequent inspection of this aircraft, an incorrect type of fuel drain wasfound fitted to its left wing. The sampling holes of thisdrain were located higher up the body of the fitting thanon the correct type such that a greater depth of fluid inthe wing remained unchecked during its operation. This might account for the significant amounts of water found in the fuel system after the accident which were not detectedin samples taken during pre-flight checks.

CAA Closure: No CAA action appropriate.

The Commander had recently ferried the helicopter from England and operated it from his home on Sotra. On the day of the accident some car parts located near Breistein ferryquay in Asane north of Bergen were to be picked up. The Commander's son and his friend came along for the flight. The helicopter was readied for the flight, which took placewithout incident. The helicopter landed on the parking area by the ferry quay and the passengers went to collect the parts while the Commander stopped the rotor. The engine was kept running and after approx 10 minutes the passengers returned. The rotor was re-engaged and the checklist forstart and take-off was completed. The helicopter then lifted to a low hover and engine performance was checked before further ascent and departure towards the sea. After approx 50m of flying, just as the helicopter passed the edge of the quay, the Commander became aware that engine RPM was decreasing. Attempts to limit the reduction in RPM were unsuccessful and the helicopter made an emergency landing in the sea approx 40m from the ferry quay. The helicopter sank immediately and one of the passengers drowned. No oneon board was wearing a life jacket. Investigation revealed that several of the engine spark plugs were

AAIB Bulletin 10/2004, ref: EW/G2004/07/15 - Summary: Thegrass strip at Stoke Golding Airfield is orientated 26/08, is 525 metres in length and 25 metres wide; at each end of the strip is a 4 foot high hedge. The strip initially slopes uphill to an apex at approximately half the strip length, after which the slope is downhill to the opposite end. Weather conditions at the time of the accident were reported as ceiling and visibility OK (CAVOK), with light andvariable winds and no significant weather. The pilot had landed on Runway 26, using an approach speed of 70kts and a threshold speed of 65kts. Touch down was made in a threepoint attitude, about 100 metres into the strip. The pilot described the grass as "wet/damp" and reported that he applied wheel braking at the point of the apex on the runway. Indications were that the wheels initially locked and skidded along the down-slope part of the strip until, at anestimated 15kts and 90 metres from the end of the strip, the braking appeared to become effective and the aircraft tipped forward and came to rest inverted. The pilot and passenger, who were wearing four-point harnesses, were uninjured. The pilot noted that the lack of headwind and dampness of the grass contributed to the accident.
CAA Closure: No CAA action appropriate.

AAIB Bulletin 4/2005, ref: EW/G2004/10/11 - Summary: After take off the pilot selected the gear up but only the left main gear locked up while the right main gear unlocked and then remained in a semi-retracted state. The pilot leftthe circuit and made numerous attempts at trying to extend both main gear using both the normal and emergency pneumatic systems. He also tried various aircraft manoeuvres including yawing, pitching and pulling 'G' but the gear indication system always showed that one landing gear was unlocked. After conducting a couple of low fly-bys at the airfield to confirm the state of the landing gear he decided to land on the grass surface alongside the paved runway. During landing both main gear collapsed, the oil cooler on the belly was torn off, and the propeller suffered damage. The pilot vacated the aircraft unassisted. An examination of the gear system revealed that the O-ring seals on the right main gear actuator piston were rolled. The rolled seals caused a leak that prevented the air pressure from fully extending both main landing gear.
CAA Closure: No CAA Action Appropriate.

AAIB Bulletin 08/2005, ref: EW/C2004/11/08 - Summary: Twomiles south of Sheffield City Airport, descending, there was a loud bang and a jolt. The pilot lowered the collective lever as a precaution for autorotation but temperatures, RPMs and pressures remained normal so he landed normally. The RH engine cowling was missing and there were small marks on the main rotor blades. Two fractured portions of the missing cowling were later found and examined by the AAIB. Each cowling panel has two hinges at top and two lowerlatches. It appears that one of the top spigot fittings had failed with cracking from previous overloads and the aft lower latch had not been fully secure. Tests showed thatthis aft lower latch can appear latched when it is not actually engaged. Through DASC, a similar occurrence (2003) was found to a British Army Gazelle, with similar conclusions. One Safety Recommendation addressed to the UK CAA (2005-049) and one Safety Recommendation (2005-050) addressedto EASA were made concerning detailed visual inspection of the fittings.
CAA Closure: CAA FACTOR F30/2005, detailing the CAA responses to the two AAIB Safety Recommendations, was issued on 9 September 2005. Any further CAA action required will be progressed via the 'Annual Review of AAIBRecommendations' procedure.

AAIB Bulletin 6/2005, ref: EW/G2004/11/11 - Summary: Shortly after the aircraft touched down on a grass runway, itslanding gear collapsed. Although the green landing gear 'down locked' light was illuminated prior to landing, it islikely that the nose gear leg was not in fact down and locked. The investigation found that misalignment of landinggear components on Piper Comanche aircraft can cause the landing gear to remain unsafe, despite cockpit indicationsto the contrary, and that failure of the nose gear to lock down prior to touch down will result in failure of the transmission system and collapse of the main gear on landing.
CAA Closure: No CAA action appropriate.

AAIB Bulletin 6/2005, ref: EW/G2004/12/01 - Summary: The aircraft was returning to Bournemouth Airport on a cross country flight from Cherbourg, France. When the pilot selected the gear down only the nose gear 'down and locked' green light illuminated. The pilot recycled the gear up then down, but again only the nose gear indicated down and locked. The pilot then tried to lock the main gear down by pulling the emergency gear extension knob, but this was unsuccessful. After reporting the problem to the control tower he performed a low fly-by. During the fly-by the tower controller reported that the main gear appeared to be extended. The pilot carried out a normal circuit to the right to land on Runway 08. Upon touchdown the right main gear leg collapsed and the right wing tip struck the runway. A maintenance organisation examined the aircraft and discovered that the hinged struts that lock the main gear down were stiff in operation. After lubricating the hinges and treating them for corrosion the gear extended and retracted normally.
CAA Closure: No CAA action appropriate.

AAIB Bulletin 3/2005, ref: EW/C2004/12/03 - Summary: About 15 minutes into the flight a loud bang was heard from the engine compartment and the engine began to run roughly. With limited power available, the pilot initiated a diversion to RAF Linton-on-Ouse. The pilot initiated a flare with excess speed and a possible throttle restriction, which may have prevented the throttle from returning to idle. The pilot was unable to land in the distance available and initiated a go-around, but when the engine did not respond the pilot carried out a forced landing in a field beyond the runway end. The aircraft hit a hedge and inverted, causing minor injuries to the two occupants. The cause of the rough running engine had not been determined at the time of publication. CAA Closure: No CAA action appropriate.
AAIB Bulletin 6/2005, ref: EW/G2004/12/12 - Summary: On 21 December 2004 at 0723 hrs, the pilot experienced high control forces in pitch when rotating the aircraft to get airborne from Edinburgh Airport. Just as the pilot was considering aborting the take off above the rotation speed, theaircraft slowly became airborne. After take off the pilotexercised the aircraft pitch controls whereupon the control forces returned to normal. The pilot then decided to continue to Manchester where an uneventful landing was made.The cause of the high control forces in pitch were probably due to frozen spring tabs caused either by incomplete de-icing before flight, or by rehydration of the de-icing fluid residue. The aircraft manufacturer has subsequently issued two All Operators Messages applicable to Dash 8 series 100, 200 and 300 aircraft following two instances of a rejected take off in the Dash 8 series 200 aircraft due tothe inability to rotate at the appropriate rotate speed. The AOMs cite as a potential cause the restriction of the spring tabs due to freezing of rehydrated de-icing fluid residue, and recommends periodic washing of specific aerodynamically "quiet" areas to remove this residue. CAA Closure: The hazard is adequately controlled by the actions stated above.
CAA Closure: Investigation revealed that a LH engine turbine blade had failed due to a fatigue crack, causing excessive vibration which in turn resulted in the failure of anoil seal leading to smoke inside the a/c. The failed blade had been mis-marked with the wrong part number by the manufacturer, allowing it to remain in service far in excessof its life limit. A review by the manufacturer confirmedthat no other such blades had been mis-labeled. Additional measures have been adopted to ensure that no further mis-identified blades will be released. See NTSB Factual Report ref: DCA04IA066, which can be viewed in full at www.ntsb.gov/ntsb.

AAIB Bulletin 12/2004, ref: EW/C2004/08/04 - Summary: During a normal landing on a grass strip, the nose wheel assembly became detached from the microlight causing it to roll forward, seriously injuring the pilot and passenger. Thefailure of the nose wheel assembly was caused by a fatigue fracture of the 'snoot', which grew from a probable defect in the weld securing the nose wheel mounting bush to the 'snoot'. The investigation report issued by the AAIB contains two Safety Recommendations (2004-89 and -90), both of which are addressed to the aircraft manufacturer.
CAA Closure: CAA FACTOR F1/2005 was issued on 13 January 2005.

AAIB Bulletin 2/2005, ref: EW/C2004/08/01 - Summary: After recycling the landing gear, consulting with company engineers and carrying out the prescribed procedure for alternate landing gear lowering, the crew were committed to landing the aircraft with a nose landing gear unsafe indication. The aircraft landed without incident; the nose landing gear indicated safe during the landing roll. Subsequent engineering investigations revealed that the Aircraft Maintenance Manual (AMM) procedure for checking the nose landinggear downlock plunger clearance was ambiguous, in that itdid not make it clear that it is necessary to apply a rearward force on the nose landing gear when checking the downlock plunger clearance. It is believed that this caused the nose landing gear downlock to be misrigged. In responseto the airline's recommendation, the aircraft manufacturer has agreed to amend the AMM procedure. See also 200306762 (similar incident, same aircraft).
CAA Closure: The hazard is adequately controlled by the actions stated above.

AAIB Bulletin 11/2005, ref: EW/G2005/02/14 - Summary: Thenewly built aircraft was on a local test flight when the engine started to run roughly and reduce in power so the pilot made a precautionary landing at Aylesbury airfield. After inspecting the engine and carrying out power checks the problem cleared so he departed again. The aircraft climbed to approximately 400ft agl before the engine started to run roughly again. As there was insufficient runway remaining to land straight ahead, he elected to carry out a short circuit. On the downwind leg the engine ceased producing all power so he landed in a field causing the gear to collapse. The pilot was able to exit unassisted. An examination of the aircraft revealed resin particles in the fuel system that could have restricted or blocked the fuel flow. The manufacturing process of the fibreglass fuel tanks was not ensuring adequate removal of all wax releasing agent from inside the tank. When the ribs were bonded to the tank using the resin, some resin was bonding inadequately to residual wax deposits inside the tank. The pilot had flushed his tanks out using water but when the tanks were subsequently filled with fuel, the fuel probably helped to remove the poorly bonded resin from the wax, leaving the resin free to enter the fuel lines. The manufacturing processhas since been improved and the build

AAIB Bulletin 1/2006, ref: EW/C2005/03/01 - Summary: Whilst the aircraft was taxiing, following an otherwise uneventful landing at Manchester, flames were seen around the wheels of the LH main landing gear. As the airport Rescue and Fire Fighting Service (RFFS) attempted to extinguish theflames, copious quantities of what the RFFS Watch Commander assessed as smoke were produced and, fearing that the fire was getting out of control, he advised the aircraft commander to evacuate the aircraft. Minor injuries were sustained by some passengers and several fire service personnel during the evacuation. The investigation determined thatthe cause of the fire, established as being in the nr10 main landing gear wheel, most likely resulted from the maintenance practice used when cleaning the wheel heat shields. It was likely that these had been immersed in a flammable solvent, which allowed the ceramic fibre insulation material contained within to become contaminated. The fire occurred on the second landing after the wheel had been fitted to the aircraft, when the brake pack temperature was likely to have been higher than on the previous landing. Foursafety recommendations have been made (2005-092, 2005-093, 2005-097 and 2005-131) of which three are addressed to the UK CAA. See also 200403454, 200403701 and
During approach, three 'Greens' illuminated but upon slowing to 50kts during the landing run, the nose landing gearslowly retracted. Damage sustained to nose landing gear and NLG doors, bottom skin in front of NLG and stringers.
AAIB Bulletin 10/2005, ref: EW/G2005/03/12 - Summary: After landing at Guernsey, the aircraft executed a 180deg turn to the left in order to backtrack the runway. After straightening up, the crew felt a violent shimmy/vibration from the left landing gear. Subsequent inspection revealed that the torque link centre bolt had failed, allowing the torque links to separate. This in turn had allowed the wheelassembly to castor about a vertical axis, resulting in damage to the tyres, wheel rims and brake components caused by the unsecured torque links. The head and shank of the failed bolt was found on the runway, together with a castellated nut and other debris. The separated, threaded tail of the bolt, onto which the nut had attached, was not found. The bolt had failed at the run-out of the threaded section, and it was concluded that the observed features on thefracture face were consistent with a tensile overload. Inside the nut, the threads had been severely damaged, consistent with an axial load having been applied in a direction away from the head of the bolt. It was not possible to establish the exact sequence of events that led to the boltfailure. Despite the extensive worldwide service experience of this aircraft type, the only similar occurrence the aircraft manufacturer was aware of involved a corrosion process. This had not happened in this

At just above 80kts but below V1 during the take off, a loud noise was heard together with severe vibration. Take off aborted and the aircraft exited the runway on a RET. Fire services attended who confirmed there was no fire and anormal disembarkation followed. Main landing gear, MLG door and flap trailing edge damaged. Debris ingested into engine. The reporter notes the fire services were contacted twice on 121.6 with no initial response and when assistingthe aircraft, fire crews could only communicate "face-to-face", in French, by opening the main door.
CAA Closure: This occurrence is subject to investigation by the Swiss Authorities. On receipt of their report the CAA's records will be updated accordingly and the occurrence may be re-opened if further investigation is deemed necessary.

AAIB Bulletin 7/2005, ref: EW/G2005/04/12 - Summary: The aircraft was conducting a PFA Annual Permit Renewal FlightTest after completion of repairs following a wheels up landing at Bembridge seven months previous (occurrence 200406231 refers). After take off when the main landing gear was selected up, the pilot saw that the nose landing gear light remained green. The pilot asked Bembridge radio if hisnosewheel had failed to retract; they reported that all of the landing gear appeared to be fully retracted. While positioning for a fly by so that ATC could take a closer look the pilot recycled the landing gear down and then up tosee if the fault would clear. On doing so the nose gear remained green throughout and both main landing gears functioned correctly. The pilot then decided that there was little point in doing the fly by so he selected the landing gear down and on obtaining three greens said that he was returning to land. As he had indications of the landing gearbeing down and locked he did not use the emergency lowering system. The pilot asked Bembridge radio on turning finals and on short finals for a visual confirmation that his landing gear was down. On both occasions they confirmed itappeared to be down. A normal approach and touchdown was flown. On lowering the nose the pilot did not feel weight being taken by the nose gear. The nose continued

AAIB Bulletin 4/2005, ref: EW/C2005/01/11 - Summary: At approximately 300 feet during the climb following take off the pilot heard the engine speed suddenly increase. The pilot quickly became aware that the belt drive from the engine to the propeller had failed before informing his passenger that the engine had failed and that they would be landing. The pilot selected a suitable field and carried out asoft field landing but unfortunately the aircraft encountered a rut during the landing roll which caused the nose landing gear to collapse. Examination of the belt drive between the engine and the propeller revealed that the belt'steeth had torn away from the belt. The pilot assessed that this had been caused by incorrect belt tension.
CAA Closure: The hazard is adequately controlled by existing requirements, procedures and documentation.

While landing on Runway 14 at Leeds Bradford, the aircraft touched down just beyond the end of the marked touchdownzone with low autobrake selected. Manual wheel braking commenced shortly after touchdown. At a groundspeed of around 70kt the brakes ceased operating for about 17 seconds. Apronounced dip in the runway initially prevented the pilots from seeing the runway end. When it became apparent that it would not be possible to stop before the runway end, the commander deliberately did not select alternate braking, as this would cause loss of nosewheel steering. Instead, nosewheel steering was used to turn sharply to the right. The aircraft skidded sideways and came to a halt with its nosewheels off the runway, just before the end of the paved surface and the start of a steep down slope. The causeof the braking loss could not be established but was consistent with the effects of excessive noise in the electrical signals from the mainwheel tachometers used to sense groundspeed. Two of the tachometer driveshafts were found bent and it was known that this encouraged a resonant condition that could cause tachometer signal errors above the groundspeed at which they would be detected. Should both main landing gears be affected simultaneously, the brake control system logic could generate an erroneous reference speed, which could

AAIB Bulletin 10/2005, ref: EW/G2005/05/14 - Summary: Following a normal start-up, the pilot lifted the helicopter into a hover when he noticed a burning smell and saw smokecoming from the area around the engine. He reported that the helicopter then lost power and he landed back on the helipad. Both the pilot and passenger exited the aircraft without injury. An exhaust pipe from the turbocharger was found detached which had allowed exhaust gases to heat the aircraft skin, leading to the smoke and fire. The exhaust pipe was maintained 'on-condition' and was visually inspected one and a half hours flying prior to the accident. Metallurgical examination of the exhaust pipe showed that it had failed due to intergranular cracking around the weld connecting the flange to the main tube. It is probable thatthe cause of the intergranular cracking was due to sensitisation of the austenitic 321 stainless steel during welding. The manufacturer's agent advised that there have been no previous reported incidents of the failure of the exhaust pipe.
CAA Closure: The hazard is acceptable provided the frequency of occurrence remains low.

AAIB Bulletin 9/2005, ref: EW/G2005/05/15 - Summary: The aircraft was being flown by a PFA approved test pilot, on conditions imposed by a 'Permit To Fly for Test Purposes'.During the approach to land the pilot attempted to increase power but the engine did not respond to throttle movements; a successful forced landing was carried out into a field. A detailed examination was carried out but no fault could be reproduced. After discussions with the PFA a further test flight was completed, during which the engine functioned satisfactorily. On a subsequent flight the pilot was again unable to restore power following a period in the descent. He therefore carried out another successful forced landing into a field. During a more extensive examination it was determined that the engine was equipped with an obsolete standard of stator for the dual ignition system. This had been the subject of a Mandatory Service Bulletin that had been issued a number of years ago. It had been applied to all engines supplied to UK customers by the UK agent and to all other operators of the type known to be operating in the UK. The Bulletin required all stators to be replaced with a modified design supplied free as an exchange component. Turbocharged versions of the Rotax 914 engineused in Europa aircraft kits supplied to the USA must be sourced from suppliers/agents in that

AAIB Bulletin 2/2006, ref: EW/C2005/05/08 - Summary: The aircraft had completed a flight to Perranporth where the landing was uneventful, as was the subsequent taxiing and airborne portion of the return flight. The pilot reported that following a normal approach to Runway 25 at Blackbushe, the aircraft touched down normally. However, when the pilot applied the brakes he felt no retardation; around 200mbefore the end of the runway, he made an R/T transmissionstating 'brake failure' and the aircraft overran the end of the runway coming to rest on a small bank in amongst some gorse bushes. There was a history of braking problems on this aircraft which had already resulted in one overrun incident. The nature of the damage to the brake pads was consistent with braking being applied resulting in little retardation. It was not possible to determine whether the incident resulted from disbonding of significant amounts offriction material, or simply from an absence of material due to excessive wear. However, metallurgical examination did produce evidence that the friction material had been bonded to an oxide layer on the backing plates, which couldhave caused a weak bond. The brakes pads fitted were not manufacturer approved parts and had been relined. The investigation report issued by the AAIB contains one Safety Recommendation (2005-145), which is
AAIB Bulletin 11/2005, ref: EW/G2005/05/25 - Summary: Thepilot and his passenger were conducting an aerial inspection of a private strip prior to its use by the passenger. No landing was planned. During the inspection the aircraftdeveloped a rough running engine and a landing was made on the strip. The pilot reported that during the subsequenttake off he sensed a sink developing which he associated with the engine problems and so he aborted the take off, causing substantial damage to the aircraft. The pilot had no recorded training in short field operations and no performance calculations had been made. No reason for the engine problem was found, though conditions were conducive to carburettor icing. Evidence suggested that the aircraft mayhave become airborne from the rough strip at a low airspeed, and encountered a light tailwind during the climb out. CAA Closure: No CAA action appropriate.

AAIB Bulletin 12/2005, ref: EW/G2005/06/11 - Summary: Prior to the accident flight the pilot carried out a pre-flight check of the aircraft and did not notice anything unusual with the landing gears. Following a successful local flight the pilot made a normal approach with the speed reducing to below 80kts when the main wheels touched down on the runway, followed a few seconds later by the nose wheel. The pilot assessed that the landing was very smooth. Aboutone second after the nosewheel touched down, the nose tipped down and the aircraft rapidly came to a halt. As the aircraft's nose tipped down, the propeller tips impacted the runway and stopped the engine. Examination of the aircraft showed that the nosewheel mounted in its attachment yoke had become detached from the nose leg. Only three of thefour yoke attachment nuts were recovered. All three nuts showed very good evidence of thread stripping which is indicative of the nuts being pulled off the attachment bolts during tensile loading. As the fourth nut was not recovered, it is possible that it may not have failed in the same way.
CAA Closure: The hazard is acceptable provided the frequency of occurrence remains low.

The failure was reported to be due to a cracked or split rigid pipe (p/n HC279B0004-000) on the green hydraulic system. This pipe is part of the high pressure system which runs from the hydraulic bay, up the fuselage side wall, tothe wing root above the passenger compartment. The part was removed and sent to NTSB. Investigation identified thattwo other hydraulic pipe leaks had been reported by the same airline. No common failure modes have been identified.See also 199602692.
CAA Closure: The hazard is acceptable provided the frequency remains low.

AAIB Bulletin 12/2005, ref: EW/G2005/06/13 - Summary: Thepilot had intended to fly to Le Touquet with a passenger.As this was to be his first flight across the channel in this aircraft he decided to perform several circuits, on the day prior to the planned flight, in order to check thatit was fully serviceable. Three such circuits were carried out, stopping after each one to perform magneto drop andtemperature and pressure checks which all proved satisfactory. After a break of about an hour he checked the fuel contents with a calibrated dipstick, confirming that he had70 litres on board, and then carried out the full pre-flight checks before lining up for take off on the grass strip with the electric fuel pump switched on. All of the required checks prior to take off were completed but, at approximately 150-200ft, the engine 'coughed' and stopped suddenly. The pilot realised that he could not land straight ahead since the field in front had numerous obstructions, including sheep, and there were similar problems to the right, so he decided to land to the left, in a field of oil seed rape. Upon touchdown the nose landing gear leg folded upwards and back but the aircraft stayed upright and, afterswitching off the electrical master switch and fuel cock,the pilot exited the aircraft normally. Injury was confined to minor scratches on both hands. G-DGHI had been builtby its owner/pilot

Subject to investigation by Sudanese authority. No injuries to 7 POB.
AAIB Bulletin 06/2006, ref: EW/C2005/06/03 - Summary: Theaircraft had departed on a scheduled passenger flight from Milan to London Heathrow Airport, with an unserviceable nr3 Air Data Inertial Reference Unit (ADIRU). On final approach to Runway 09L at London Heathrow in Instrument Meteorological Conditions (IMC), the Inertial Reference (IR) part of the Nr1 ADIRU failed, depriving the commander (the pilot flying) of much of the information on his Primary Flight and Navigation Displays. ATC required the aircraft to go-around from a height of 200ft on short final approach due to another aircraft still occupying the runway. The co-pilot, who had been handed control, performed the go-around and the aircraft was radar vectored for a second approach. The crew then turned off the Nr1 ADIRU whilst attempting to diagnose the problem, contrary to prescribed procedures. As a result, additional data were lost from the commander's electronic instrument displays, the nosewheel steering became inoperative, and it became necessary to lower the landing gear by gravity extension. At a range of 11nm from touchdown, when the commander transmitted "ON FINAL, MAYDAY FROM THIS MOMENT, WE CANNOT PERFORM A GO AROUND, AH FINALS 09L", the MAYDAY element of this call was not heard by the controller. This was
AAIB Bulletin 10/2005, ref: EW/G2005/06/27 - Summary: Prior to the accident flight the aircraft had twice been flown earlier in the day with each flight lasting about one hour. The aircraft was then refuelled using three gallons ofunleaded MOGAS, obtained from a local garage. Following anormal engine start the aircraft taxied out, took off andclimbed away apparently normally. As it passed 300ft, an uncommanded reduction in power occurred, coupled with a gentle turn to the right. An attempt was then made to restore engine power, but there was little response from the throttle. When it was moved back and then reapplied, the engine stopped. A forced landing was carried out in field of long grass but, as the nose came down after the main wheelshad touched, the nose gear collapsed. The pilot and his passenger, who were wearing lap strap and diagonal harnesses, exited the aircraft without injury. Following the accident the propeller was free to turn and fuel was found in the float chamber of both carburettors. Also an inspection of the fuel filters showed them to be clean. The weather at the time of the accident was observed as being a wind of5kt from 135deg with good visibility. The temperature was19deg C with a dew point of 13deg C, and this placed the engine in the 'moderate icing at cruise power and serious icing at descent power' area of the carburettor

AAIB Bulletin 1/2006, ref: EW/C2005/01/04 - Summary: The aircraft's left overwing emergency escape hatch detached from the aircraft during take off from East Midlands Airport. A deferred technical defect in the aircraft's pressurisation system meant that the loss of the hatch was only discovered after landing at Ronaldsway Airport on the Isle ofMan. The investigation established that a protective cover, in the cargo area, intended to prevent inadvertent operation of the overwing emergency escape hatch handle, was not attached prior to loading and that movement of the cargo probably caused the handle to move to the 'open' position, allowing the hatch to detach from the aircraft. The investigation also established that a number of deficiencies existed in the operator's training and oversight of contracted loading staff. Four safety recommendations (2005-140 to 2005-143) are made.

CAA Closure: CAA FACTOR F6/2006, detailing the CAA responses to the four AAIB Safety Recommendations, was issued on 10 March 2006. Any further CAA action required will be progressed via the 'Annual Review of AAIB Recommendations' procedure.

AAIB Bulletin 11/2005, ref: EW/G2005/20/05 - Summary: As the aircraft commenced its take off run, the take off warning horn sounded. The take off was rejected, but while taxiing for another attempt, the pilots noticed a burning smell on the flight deck. When advised by the cabin crew thatthere was also a smell of burning and some smoke in the cabin, the commander stopped the aircraft on the taxiway and initiated an expeditious disembarkation using the forward passenger door only. An engineering investigation carried out by the operator's maintenance personnel and the engine manufacturer found that a piece of the right hand engine compressor inner support had become detached, causing damage to a compressor oil seal and allowing oil to contaminate the engine bleed air. The engine manufacturer is awareof the issues and is addressing them through component re-design and engine modifications.

CAA Closure: The hazardis adequately controlled by the actions stated above.

AAIB Bulletin 7/2005, ref: EW/G2005/02/04 - Summary: The purpose of the flight was for an instructor to revalidate the pilot's Private Pilot's Licence. The intention was to practice circuits followed by upper air work and a short cross-country with a practice forced landing. After the instructor had demonstrated a 'three-point' landing, the pilot performed a 'wheeler' landing, intending to allow the tail to settle before applying power to go around. However, before the tailskid touched, the right undercarriage collapsed and the aircraft tipped onto its nose and right wingtip before settling back in an upright attitude. The instructor reported that the touchdown was normal and states that the damage was relatively light due to the low groundspeed at the time of the collapse. Both pilots evacuated the aircraft normally. The instructor, who is a retired metallurgist, found that the right undercarriage drag strut had detached from the fitting securing it to the fuselage due to failure of the swivel bolt, part number H.22186. On a brief visual examination, he diagnosed that the fracture involved a fatigue crack. One half of the fracture was sent to the AAIB for examination: this concurred with his diagnosis with the additional observation that it appeared to be low-cycle fatigue occurring over a relatively short period and that the bolt passing through the strut fork fitting

AAIB Bulletin 11/2005, ref: EW/G2005/07/01 - Summary: Theaircraft was an amateur-built monoplane of composite construction powered by a two-cylinder two-stroke engine. The pilot was flying from Deanland to the PFA Rally at Kemble.The wind was light and the pilot used Runway 26 for take off. At about 300ft agl, the engine 'popped' abruptly and then stopped completely. The pilot attempted a re-start and the engine appeared to start but then promptly stopped. At 150ft the pilot trimmed for landing into a large field,containing a tall crop. The descent rate and approach speed into the field were reasonable but, as the wing contacted the crop, the aircraft decelerated rapidly and pitched nose down, stopping within a few metres. There was no fireand the pilot was uninjured. Both carburettor float bowlscontained sediment, sufficient to restrict the supply of fuel into the engine. Larger items of sediment appeared tobe small flakes of red paint, matching the fuel supply cans. The pilot noted the fuel filter element had not been fully screwed home and could therefore 'rock' in place. Thepilot also considered that he should have refuelled through a proper external strainer to filter the fuel into the tank.
CAA Closure: No CAA action appropriate.

AAIB Bulletin 2/2006, ref: EW/G2005/07/07 - Summary: The pilot planned to fly the aircraft once it had returned from a previous flight. Prior to take off the aircraft had tohold for 5 minutes, on dry grass, while a glider that hadjust landed was recovered. During this period the engine speed was maintained at 1100rpm. The OAT was +25deg C. Soon after take off there was a progressive reduction in engine power. Being at about 80ft, the pilot realised that he was too high to land in what remained of the airfield ahead. The engine then stopped completely and the aircraft descended striking the airfield boundary fence before coming to rest. The pilot vacated the aircraft unassisted and without injury. Given that the engine was already warm from its previous flight and the normal air supply to the carburettor would have provided very warm air as a consequence of its low flow rate through the engine compartment in the absence of any ram effect, it is therefore considered thatthese conditions were ideal for the formation of a vapourlock in the fuel line. CAA Closure: No CAA action appropriate.
AAIB Bulletin 12/2005, ref: EW/G2005/09/03 - Summary: Thepilot reported that whilst preparing to land at North Weald Aerodrome to take on fuel, he became aware that he did not have a 'three greens' undercarriage indication in the cockpit. Air Traffic Control subsequently confirmed that the main landing gear did not appear to be fully extended. The pilot embarked on a period of circling in the local area whilst he attempted to extend the gear fully, both by cycling the retraction system electrically and by using themanual crank mechanism. These attempts were abandoned after about 30 minutes, when an electrical burning smell became apparent and the gear had still failed to lock down correctly. Subsequently, a gentle touchdown was accomplished on the grass adjoining the runway with the gear in a partially extended condition, following which the gear collapsed and the aircraft subsided onto its fuselage. After sliding a short distance, it came to rest and the pilot disembarked. The aircraft was examined subsequently by an insurance assessor who reported that, after the aircraft had beenlifted and appropriately supported, he was able manually to extend and lock down all three landing gears. However, deformations of the various rods and cranks which made up the electrically actuated system, caused by the gear collapsing after touchdown, prevented him
AAIB Bulletin 1/2006, ref: EW/G2005/09/05 - Summary: Shortly after taking off, the engine suffered a reduction in power, as a result of a sticking exhaust valve, that required the pilot to undertake a forced landing within the airfield perimeter. The aircraft landed heavily, which resulted in the collapse of the LH landing gear and the propellerblades striking the ground. CAA Closure: No CAA action appropriate.
Subject to NTSB investigation.

AAIB Bulletin 5/2006, ref: EW/G2005/09/10 - Summary: On approach to Humberside Airport the pilot selected the landing gear to the down position; the landing gear position indicators showed that all three units were down and locked.After landing on the main wheels the nose of the aircraftwas lowered and the nose landing gear collapsed. The aircraft continued along the runway on its main landing gear and nose fairing for approximately 120m before coming to a halt. The collapse of the nose landing gear was caused by the geometric locking mechanism becoming ineffective.
CAAClosure: The hazard is adequately controlled by existing requirements, procedures and documentation.

AAIB Bulletin 2/2006, ref: EW/G2005/10/11 - Summary: During a test flight from Ashcroft airfield for the purpose ofrenewing the aircraft's Permit to Fly, the pilot noticed that spots of oil were appearing on the windscreen and attempted to return to the airfield to investigate the problem. On final approach to grass Runway 27, the aircraft stalled and touched down in a farm field approximately 50 metres short of the runway threshold. The pilot's assessment of the cause was that, pre-occupied by the need to land immediately, he had allowed the airspeed to decay during the final approach and the aircraft stalled before he was ableto initiate an effective recovery. When he inspected the aircraft immediately after the accident, the pilot found that the return oil pipe had become detached from a recently fitted air/oil separator. He determined that this was probably the cause of oil contamination of the windscreen.
CAA Closure: No CAA action appropriate.

AAIB Bulletin 2/2006, ref: EW/G2005/07/17 - Summary: On take off the engine stopped when the aircraft passed about 200ft agl. During the ensuing forced landing it stalled closed to the ground causing it to crash. The engine was operating on Motor Gasoline and the ambient temperature at the time was about 24deg C. Prior to take off the aircraft had also been parked for about thirty minutes with the engine still hot from a previous flight. It is thought that parking the aircraft under such conditions led to fuel vapourising in the fuel system, leading to vapour lock during the subsequent take off. The CAA and PFA state a maximum fuel tank temperature of 20deg C for operating on MOGAS.
CAA Closure: No CAA action appropriate.

AAIB Bulletin 10/2005, ref: EW/G2005/07/20 - Summary: Thepilot made a normal approach to grass Runway 03 at Popham. During the flare prior to landing, the hand grip of the control column slid off the column allowing the nose to pitch down. Before the pilot could regain control, the nose hit the ground and the aircraft pitched over onto its back. The pilot, who was wearing a 4 point harness, was able to vacate the aircraft's open cockpit without injury. The hand grip was made from turned wood and held onto the control column using a friction fit. During recent hot weather,the wooden grip had cracked, allowing it to move freely on the steel shaft of the control column. A new grip is currently being manufactured from aluminium which will be secured onto the control column by a retaining bolt.

CAA Closure: The hazard is adequately controlled by the actions stated above.

AAIB Bulletin 2/2006, ref: EW/G2005/07/35 - Summary: The pilot had carried out a short local area flight with threepassengers. He decided to land at a private site and having checked the site for obstructions, he performed a normal approach into wind. At about 100ft, the intermittent engine out audio tone was heard and the pilot entered autorotation. At about the same time, the pilot heard the steady tone of the low rotor RPM audio warning and saw the illuminated 'Rot Low rpm' caption on the CWP. He flared the helicopter whilst simultaneously checking the rate of descent with the collective lever. These control inputs were accompanied by a loud bang. The helicopter was landed and shutdown. The main rotor blades had contacted the tail pylon aft of the horizontal stabiliser severing the pylon.

CAA Closure: No CAA action appropriate.

AAIB Bulletin 11/2006, ref: EW/C2005/10/04 - Summary: Shortly after take off the aircraft experienced an engine problem which was probably the result of water contamination of the fuel. In the resultant situation, the recommended option was to land straight ahead into a field. However, possibly influenced by a partial engine recovery, the commander decided to attempt to turn back towards the departure runway. The aircraft had turned through approximately 180deg to the left when it stalled and crashed. The investigation report issued by the AAIB contained two Safety Recommendations (2006-075 and 2006-109).

CAA Closure: CAA FACTORF41/2006, detailing the CAA responses to the two AAIB Safety Recommendations, was issued on 10 November 2006. Any further CAA action required will be progressed via the 'Annual Review of AAIB Recommendations' procedure.

AAIB Bulletin 4/2006, ref: EW/G2005/10/24 - Summary: The aircraft was on a short positioning flight during which the pilot was unable to successfully deploy the landing gear, either by normal control selection or by using the manual pump. The pilot elected to divert to Cambridge City Airport and made a successful gear up landing; the aircraft sustaining damage to the propeller and the underside of the fuselage. The inability to deploy the landing gear has since been attributed to incorrectly installed wiring for thesquat switch on the nose landing gear. The squat switch had recently been replaced. CAA Closure: The hazard is acceptable provided the frequency of occurrence remains low.
AAIB Bulletin 2/2006, ref: EW/G2005/11/08 - Summary: The aircraft suffered an engine failure after take off when ata height of 200ft. Due to lack of a suitable landing field straight ahead the pilot attempted a downwind landing ona taxiway which resulted in the aircraft somersaulting following a landing on soft ground adjacent to the taxiway. It sustained substantial damage; the pilot received minor injuries and exited the aircraft unassisted. The most probable cause of the engine failure was an internal defect within the magneto generator, resulting in a loss of power to the engine ignition system. CAA Closure: The hazard is acceptable provided the frequency of occurrence remains low.
AAIB Bulletin 5/2006, ref: EW/G2005/11/13 - Summary: Whilst conducting a short test flight, following engine groundruns to investigate rough running on the previous flight,the engine lost power shortly after take off. During the enforced landing, the aircraft skidded into a dry stone wall and was seriously damaged. Examination of the aircraft some weeks after the accident revealed the presence of water in the fuel system. CAA Closure: No CAA action appropriate.
AAIB Bulletin 4/2006, ref: EW/G2005/11/24 - Summary: The aircraft was returning to Swansea from Exeter following repairs after a heavy landing. After completing one 'touch and go' the pilot rejoined the circuit. When the landing gear was selected 'down' the pilot observed a 'gear unsafe' warning light. After recycling the landing gear, the control tower reported that the nose leg had not extended. The pilot then made several unsuccessful attempts to lower it using the normal electrically powered system, before trying the emergency hand pump. After several minutes of pumping the control tower advised that the nose gear was only partially extended. The pilot then elected to carry out a landing with the nose landing gear in this condition, which collapsed as the nose wheel touched the runway. With the possible exception of the landing gear system circuit breaker, no pre-accident defects were identified with the landing gear operating system. CAA Closure: No CAA action appropriate.

CAA Closure: During a landing on R/W10, the aircraft cameto rest in the undershoot area of R/W28, having burst allfour main landing gear tyres. It was established that thelift spoilers had not deployed after touchdown. The lack of normal deceleration resulted in the flight crew selecting the braking hydraulic system to Yellow from Green, and then to the Emergency Yellow system; this system provides no anti-skid protection for the wheels. The combination oftouching down at a speed higher than was appropriate for the aircraft's weight at the end of the touchdown zone, the failure of the lift spoilers to deploy at any time during the landing roll, the commander's mistaken belief that the aircraft's wheel braking systems had failed, and an incorrect braking technique, combined to cause the aircraft to overrun the specified landing distance available. Use ofthe emergency brake system, which is not fitted with anti-skid protection, caused all four main landing gear tyres to burst. Three Safety Recommendations, nrs 2008-062 addressed to EASA, 2008-063 addressed to the operator and 2008-064 also addressed to the operator are made. See AAIB Bulletin 10/2009, ref: EW/C2007/02/06, Air Accident Report: 5/2009.
The tail wheeled aircraft took off from a private airfield in Navan, for a ferry flight to a neighbouring airfield at Athboy, a few miles distant. On climb out, the pilot attempted to correct a tendency to swing left with application of right rudder. However, even full right rudder input failed to fully correct this tendency. On landing at Athboy, a crosswind weathercocked the aircraft to the left and,with insufficient right rudder available to the pilot, the aircraft impacted a ditch and came to rest. Subsequent investigation showed considerable play between the right pedal bolt and its attachment to the torque tube. AAIU Synoptic Report No: 2006-022 refers. The full AAIU report can be viewed at www.aaiu.ie.
AAIB Bulletin 5/2006, ref: EW/G2005/07/28 - Summary: The pilot was attempting to take off from Runway 17 at Derby Airfield. The field performance was marginal and the aircraft failed to accelerate normally; it ran off the end of the grass runway at about 50kt. The aircraft hit a hedge andran into a ditch, causing extensive damage to the aircraft and serious injuries to the two occupants. Examination of the engine revealed that a maintenance error had allowedan induction air leak downstream of the carburettor. The investigation concluded that the accident occurred becausethe pilot did not recognise the slow acceleration in timeto safely abort the take off. CAA Closure: The hazard isadequately controlled by existing requirements, procedures and documentation.

AAIB Bulletin 4/2006, ref: EW/G2005/07/37 - Summary: The aircraft had been positioned at Nottingham East Midlands Airport early in the morning of 30 July 2005, following which various maintenance activities took place, including changing the nr3 wheel brake unit. The aircraft subsequentlytook off to fly training circuits but, on the second touch-and-go, the Control Tower advised the crew that flames were seen to be coming from the right main landing gear. The commander elected to continue the touch-and-go and to fly a circuit with the landing gear down, as he was concerned about stopping the aircraft in the runway distance remaining. After a successful landing, the aircraft was broughtto a stop on the runway and inspected by the fire service, prior to being towed to a stand. The fire was later attributed to a failure in the nr3 brake unit. This was causedby the end cap of the brake torque rod not being refittedduring the maintenance activity, thus allowing one end ofthe brake torque rod to become detached and scrape along the ground during the landing. The brake unit rotated withthe wheel during the rollout, causing damage to the wheel, severance of the brake hose and damage to the brake temperature monitoring components. As a result of their investigation, the operator's Safety Department has recommended the implementation of appropriate safety actions to the

AAIB Bulletin 12/2005, ref: EW/G2005/08/03 - Summary: Thepilot was returning after a formation flight that involved nine aircraft flying over Stonehenge. D-EZOZ was number four in the formation and was briefed to land fourth. During the landing, the right main landing gear leg broke andbegan to dig into the grass, causing the aircraft to yaw to the right and slide to a rapid stop. During the slide the left main landing gear was also damaged. All of the propeller blades had suffered impact damage and the engine was shock-loaded. The repair agency stated that the maintenance schedule requires routine visual inspection of the landing gear, but no routine load testing. Thus, there was the possibility of a pre-existing weakness in the main landing gear.□
CAA Closure: No CAA action appropriate.

AAIB Bulletin 1/2006, ref: EW/G2005/08/08 - Summary: At the conclusion of a trial lesson, the instructor was returning to Cardiff Airport at 1400ft on the published Cardiff Docks arrival when the engine started to vibrate. The vibration was slight to begin with but became rapidly worse and, after checking carburettor heat and magnetos, the pilottransmitted a PAN call to Cardiff Radar, turning the aircraft away from the bay area towards fields to the north east of Cardiff as he expected to make a precautionary landing. The vibration became severe, accompanied by a loud mechanical banging sound and the airspeed was decreasing, so the pilot reduced engine rpm and sought the nearest suitable field, transmitting a MAYDAY call before concentrating on the landing. The aircraft was landed in a grass field and touchdown was made at minimum airspeed with 40deg flap selected. The grass was wet and, despite application of the wheel brakes, the aircraft overran the field boundary, passing through brambles and a wire fence. The left wing struck a fence post, turning the aircraft through 90deg before it came to rest on a minor road with the nose landing gear collapsed. The instructor and student vacated the aircraft normally and without injury. Subsequent engineering examination of the aircraft found that the nr2 engine cylinder had a large circumferential crack around the base of the

AAIB Bulletin 8/2007, ref: EW/G2007/03/02 - Summary: After extending the landing gear the green light, to indicate that the landing gear was down and locked, did not illuminate, but a visual inspection through the clear panel in the nose gear bay revealed that the nose gear appeared to befully extended. The pilot pulled the circuit breaker for the electric gear extension and then applied the manual handle for gear extension, but no further movement could be obtained. He raised the gear partially using the manual handle and then re-extended it, resulting in the nose gear returning to its original position. He therefore assumed that the gear was extended and that there was a light indication problem. The pilot carried out a normal approach and landing, but when the nose of the aircraft was lowered, the nose gear collapsed and the propeller struck the ground.The aircraft slid to a stop with its lower cowling resting on the ground. The pilot examined the aircraft and discovered that a wiring loom had jammed the nose gear screwjack. This prevented the nose gear from fully extending and prevented the over-centre downlock from engaging.
CAA Closure: The hazard is acceptable provided the frequency of occurrence remains low.

AAIB Bulletin 12/2005, ref: EW/G2005/08/09 Summary: The aircraft was engaged in aerotow operations at Lasham Airfield and was in the process of carrying out its second glider launch after refuelling. At about 30ft after take off, the pilot sensed the glider release and, upon checking in the mirror, saw smoke and heard a radio call announcing that the aircraft was on fire. She responded by immediately closing the throttle and landing straight ahead, touching down on the grass strip to the north of the paved runway, and completing the 'immediate actions' for engine fire during the latter part of the landing. As the aircraft decelerated, she steered back onto the hard runway and applied maximum braking but was unable to stop before running off the end of the paved surface. The aircraft came to rest approximately 20m into the grass overshoot area for Runway 27 and, after confirming that the ignition, fuel and electrics were OFF, the pilot vacated the aircraft in the normal manner. By this stage, smoke was already entering the cockpit and flames were visible outside the aircraft. The pilothad a quick look for the fire extinguisher, but as the fire was already burning quite fiercely, she decided it was safer to vacate the area. Because it presented no threat to life, no attempt was made to extinguish the fire subsequently and the aircraft was totally destroyed. The tug
AAIB Bulletin 7/2007, ref: EW/G2007/03/04 - Summary: After take-off, on climbing through 300 to 400 feet, the aircraft engine suddenly stopped. The pilot made a forced landing in a field during which the landing gear collapsed. Thecause of the engine failure has not been determined.□ CAAClosure: No CAA action appropriate.
AAIB Bulletin 5/2008, ref: EW/C2007/03/06 - Summary: Immediately after take-off on a night flight from Stansted to Edinburgh, the flight crew experienced control difficulties and fluctuation of the RPM and power on all four engines. As the aircraft climbed towards 3,000 feet QNH the number 2 engine was observed to be running down. The crew shut the engine down, declared a PAN and prepared to return to Stansted. The remaining three engines continued to suffer from fluctuating parameters throughout the remainder of the flight until, when on final approach with landing flap selected, both the number 1 and number 3 engines appeared to run down. The aircraft landed using the remaining engine. The investigation revealed that the incident was the result of a failure of the propeller synchrophaser.□ CAA Closure: The operator, in consultation with the UK CAA, has amended its procedures to include the checklist items specific for multiple propeller malfunctions on G-FIZU that had been erroneously omitted. They have also informed crews ofthe incident and of the revised procedures now in force so that they will be able to identify any recurrence in thefuture and take effective remedial action. A review carried out by the airframe

AAIB Bulletin 6/2007, ref: EW/G2007/03/12 - Summary: Following a parachute drop the pilot commenced a descent to land. The descent was uneventful and the approach and landing checks were completed. At about 500 feet the pilot became aware that the engine had failed. The pilot changed fueltanks but there was no response from the engine. He quickly realised that he did not have sufficient height to landon the airfield and elected to land in an undershoot field. The ground was of a heavy clay-type soil and the aircraft came to a halt very rapidly, having collapsed all threelanding gear legs. The fuel state was low and the aircraft would have required refuelling prior to the next flight but, in the pilot's estimate, there was a total of approximately 30 litres in the two tanks. The cause of the enginefailure was not established. CAA Closure: No CAA action appropriate.
AAIB Bulletin 4/2008, ref: EW/C2007/03/07 - Summary: After selecting the landing gear to UP after take-off from Caen, the 'gear unsafe' light remained on. The flight crew established that the nose landing gear had neither retractednor remained locked down and, despite recycling the gear and attempting to use the emergency gear lowering system, the crew were unable to lock the leg down. On landing at Southend Airport, the nose leg collapsed, causing damage tothe fuselage nose structure and the propeller blade tips.The investigation revealed that the nose gear actuator had been affected internally by corrosion, resulting from water ingress, which led to the failure of the threads within the actuation nut of the actuator. It had completed a total of 1,449 cycles of its 8,000 cycle life, but only 532 cycles since its last 1,000 cycle check. One Safety Recommendation (2007-126) was issued and is addressed to the FAA. CAA Closure: The recommendation made in respect of thisoccurrence is not addressed to the CAA and is to be actioned directly by the relevant body. No further CAA action is practicable.
CAA Closure: Occurrence closed with no further investigation being progressed by either the UK or German authorities.
AAIB Bulletin 9/2007, ref: EW/G2007/03/13 - Summary: One of the propeller blades detached from the hub following a touch-and-go landing. During the subsequent forced landingthe aircraft struck a hedge and was severely damaged. Thewreckage was removed and the damaged parts were disposed of without being photographed before any investigation could take place. Therefore, the cause of the blade failure could not be determined. CAA Closure: No further CAA action practicable.

AAIB Bulletin 8/2007, ref: EW/G2007/04/06 - Summary: Shortly after take-off, the engine began to lose power and thepilot was forced to land in a field. In attempting to avoid a ditch, the left main landing gear collapsed. It was established that the rear cylinder big-end bearing of the two cylinder 2 two-stroke engine had failed. CAA Closure: No further CAA action required at this time.
AAIB Bulletin 3/2008, ref: EW/C2007/04/04 - Summary: The pilot attempted to return the aircraft to the runway afterit suffered a loss of power shortly after take-off. The aircraft had insufficient performance to complete this manoeuvre and stalled before the pilot was able to make a controlled landing. The investigation did not determine the cause of the loss of power. CAA Closure: No further CAA action practicable.
AAIB Bulletin 9/2007, ref: EW/G2007/04/14 - Summary: During the climb following a touch-and-go landing, the aircraft's engine 'spluttered' and then stopped. The pilot was unable to restart it, and carried out a forced landing into a field. No definite cause of the engine failure has been identified. CAA Closure: No further CAA action practicable.
AAIB Bulletin 8/2007, ref: EW/G2007/04/13 - Summary: Shortly after the aircraft touched down, it hit a bump in the runway causing it to become airborne again. On the second touch down the left main landing gear collapsed. The causeof the accident was the failure of the left main landing gear securing bolt. CAA Closure: No further CAA action required at this time.
AAIB Bulletin 9/2007, ref: EW/G2007/01/15 - Summary: Immediately after take-off from Durham Tees Valley Airport, the crew found difficulty in controlling the aircraft in pitch using the control yoke. They found that the pitch trim wheel and engine condition lever friction wheel had lockedtogether, jamming both controls. The aircraft returned tothe airport with the crew using engine power to assist incontrolling pitch and an uneventful landing was made. Investigation found that the condition lever friction wheel, which rotates about a common shaft with the elevator manual trim wheel, had made contact with the trim wheel such that application of nose-down elevator trim also caused rotation of the friction wheel in the 'tighten' sense until the two had jammed together. When the two wheels were freed,both mechanisms worked correctly. The aircraft manufacturer had previously issued AOM 99/006J, which describes similar symptoms caused by the displacement or incorrect fitment of a circlip designed to prevent axial movement of the trim wheel along the shaft it shares with the condition levers. The AOM recommended a 'one-off' inspection to ensurethat the circlip was correctly seated and the operator ofG-MAJI had introduced an additional requirement to check the circlip at 600 hour intervals. A suitable caution was also added to the AMM.

AAIB Bulletin 2/2008, ref: EW/C2007/01/02 - Summary: The aircraft suffered a failure of the Nr3 hydraulic system when lowering the landing gear on approach. The commander took what he believed to be the necessary actions prior to landing but without apparent reference to the Quick Reference Handbook (QRH). As a result the aircraft landed with one of the Nr3 hydraulic system pumps still running and the nosewheel steering 'On', contrary to instructions in the QRH. This resulted in an uncommanded steering input to the right after touchdown and the aircraft departed the runway. One Safety Recommendation (2007-101) has been issued andis addressed to the aircraft manufacturer.
CAA Closure: The recommendation made in respect of this occurrence is not addressed to the CAA and is to be actioned directly by the relevant body. No further CAA action is practicable.

AAIB Bulletin 10/2007, ref: EW/C2007/01/12 - Summary: During the rollout, following an uneventful flight, the rightmain landing gear (MLG) collapsed. Subsequent investigation revealed a fatigue failure and overload of the arm attachment holes on the right MLG torque tube. The crack appeared to have been growing since around 200. A SupplementaryInspection Document (SID) issued by Cessna in 2004 recommended inspections of the arm attachment holes of the torque tube but the inspection had not been carried out on N401JN. This SID is mandatory on aircraft registered in Europeused for commercial air transport, and will be mandatory from September 2008 for those used privately (CAA LTO No. 2851 Revision A refers). The SID is not mandatory for US-registered aircraft, such as N401JN. One Safety Recommendation (2007-059) has been made and is addressed to the FAA.CAA Closure: The Recommendation made in respect of this occurrence is not addressed to the CAA and is to be actioned directly by the relevant body. No further CAA action is practicable.

AAIB Bulletin 2/2008, ref: EW/C2007/04/06 - Summary: The accident occurred during a solo flight, the purpose of which was to convert an experienced glider pilot on to type. On approach, the glider was seen to enter a steep dive andstrike the ground, seriously injuring the pilot. The divewas caused by the failure of a piece of electric cable being used to restrain the hinged rear cockpit headrest. This allowed the headrest to fall forward, restricting the rearward travel of the rear cockpit control column resultingin a loss of control. The electrical cable had been fitted as a replacement for the original nylon cord, installed by the manufacturer, which had become damaged. Two Safety Recommendations (2007-127 and -128) have been made to the German LBA, EASA and the aircraft manufacturer.
CAA Closure: The Recommendations made in respect of this occurrenceare not addressed to the CAA and are to be actioned directly by the relevant bodies. No further CAA action is practicable.

AAIB Bulletin 2/2008, ref: EW/C2007/06/05 - Summary: The landing gear seized in the partially extended position andduring the subsequent landing, the nose gear collapsed allowing the propeller to make contact with the runway. The investigation report issued by the AAIB contains one Safety Recommendation (2007-113) regarding the risks involved in resetting circuit breakers in flight. CAA Closure: CAA FACTOR F5/2008, detailing the CAA's response to the one AAIB Safety Recommendation, was issued on 10 March 2008. Anyfurther CAA action required will be progressed via the 'Annual Review of AAIB Recommendations' procedure.
The engine was sent back to OEM for investigation. The failure has been attributed to failure of a power turbine blade. Whilst the engine had only completed 10 hours since shop visit for repair, the power turbine module was not disassembled during that visit, and the failure is not attributable to the repair work carried out. It is therefore considered that no further action is required at this time. CAA will, however, continue to monitor any reports of bladefailure to determine any possible adverse trend. CAA Closure: No further CAA action required at this time.
AAIB Bulletin, ref: EW/G2007/07/04 - Summary: The aircraft touched down with the landing gear in an unsafe condition. During the landing roll, the nose and left main landinggear collapsed, causing the aircraft to veer to the left side of the runway. The left wing, nose cowl and propellerof the aircraft were damaged, but the occupants were uninjured. CAA Closure: No CAA action practicable.
CAA Closure: Failure of the right gear hydraulic actuatorwhen the landing gear was selected down led to the loss of the hydraulic fluid in the system. The emergency lowering system was used, which deployed the left and nose landing gears, but the right gear remained retracted. A successful emergency landing was subsequently carried out. Examination of the actuator revealed the presence of pre-existingstress corrosion and critical cracking, in the actuator body. It was concluded that the failure was associated withthe maritime environment in which the aircraft had operated, possibly exacerbated by very thin anodic coating. AAIBBulletin 5/2008, ref: EW/G2007/07/09 refers.

AAIB Bulletin 9/2007, ref: EW/C2007/05/07 - Summary: Shortly after taking off from Leicester Airport, all thrust was lost from the propeller. A forced landing was made on tothe disused section of the runway, where the aircraft sustained some damage. After coming to a halt the engine continued to run, but at idle speed. It was established that afailure had occurred in the propeller control unit, leading to a loss of controlling oil pressure to the propeller hub. This resulted in the propeller blades moving to the coarse pitch angle stops. The pilot was unaware of this characteristic of the propeller, as this had not been coveredin his training. Also, no reference to this was made in the aircraft's Flight Manual. One Safety Recommendation (2007-054) is made. CAA Closure: CAA FACTOR F34/2007, detailing the CAA's response to the one AAIB Safety Recommendation, was issued on 10 October 2007. Any further CAA action required will be progressed via the 'Annual Review of AAIBRecommendations' procedure.
CAA Closure: On departing from Leicester, the pilot observed a low voltage indication and returned to make a precautionary landing. Whilst on short final for Runway 33, he became aware of vehicles near the runway threshold and accordingly, landed long. The aircraft bounced after touchdownand he decided to go around. During the climb out the engine began to lose power and he attempted to land downwind on another runway, but the aircraft was too high and too fast. After crossing the aerodrome eastern boundary, the aircraft stalled from a low height and impacted the ground heavily, following which a fire broke out. The pilot suffered back and facial injuries. See AAIB Bulletin 1/2009, ref: EW/C2007/08/03.
Whilst climbing through about 8,500 feet to drop 13 parachutists the aircraft inadvertently entered cloud. The pilot began a descent and regained VMC at about 4,000 feet, however he stated one of the engines ran down due to icing before he was able to select the engine anti-ice system on.He was unable to restart the engine and returned to his departure airfield, flying high and fast on the approach, as he said he had been trained to do whilst landing in a single-engined configuration. The aircraft landed long and was unable to stop before the end of the runway. The aircraft overshot and the nose wheel entered a ditch causing it to collapse. The pilot did not hold a type rating for the aircraft, as required under CAA and JAR regulations, but was operating under an FAA licence, based on his CAA licence, which he incorrectly believed did not require a specific type rating. The investigation report issued by the AAIBcontains one Safety Recommendation (2008-031), which is addressed to the FAA. See AAIB Bulletin 8/2008, ref: EW/C2007/08/11. CAA Closure: The Recommendation made in respectof this occurrence is not addressed to the CAA and is to be actioned directly by the relevant body. No further CAA action is practicable.

See AAIB Bulletin 10/2007, ref: EW/G2007/08/11. CAA Closure: No CAA action appropriate.
AAIB Bulletin 12/2007, ref: EW/G2007/08/23 - Summary: TheNo.2 tyre tread was shed during the landing; there was damage to the left engine, the left flap and hydraulic linesin the left wheel well. CAA Closure: No further CAA action practicable.
AAIB Bulletin 11/2007, ref: EW/G2007/08/24 - Summary: When landing downwind, following in-flight opening of a canopy door, the aircraft flipped inverted. CAA Closure: No CAA action appropriate.
CAA Closure: During take-off from a grass farm strip, theengine failed. The pilot carried out a forced landing in a wheat field but the aircraft clipped a hedge and inverted. The pilot assessed the cause of the power failure to have been due to a blocked vent in the fuel tank cap. See AAIB Bulletin 8/2008, ref: EW/G2007/07/15.
AAIB Bulletin 11/2007, ref: EW/G2007/05/10 - Summary: During the latter stages of take-off from Exeter Airport, theaircraft swung sharply to the right. Application of left brake and rudder failed to correct the swing; the take-offwas aborted but the aircraft departed the runway to the right. During the deceleration, the right main landing gearfailed, which allowed the right external fuel tank to hitthe ground and burst. The pilot shut down the engine before the aircraft came to a halt. There was no fire and boththe pilot and the passenger escaped unhurt. The cause of the accident was traced to a failure within the wheel brakes selector unit, which allowed pressure to be continuously applied to the right brake unit during the take-off run.The heat consequently generated, resulted in the right brake unit's seizure, causing the aircraft to swing uncontrollably. The brake selector unit is not subject to a fixed life and it was not determined when this unit had been fitted to the aircraft. As a result of this event, the maintenance organisation has introduced routine spectrographic oil analysis of the hydraulic fluid within the brake systemto allow early identification of component deterioration. CAA Closure: The hazard is adequately controlled by the actions stated
AAIB Bulletin 9/2007, ref: EW/G2007/05/11 - Summary: The aircraft, whilst undergoing a test flight, suffered a seizure in the landing gear extension/retraction system which resulted in the landing gear becoming stuck in the almost fully retracted position. A landing was carried out which resulted in some damage to the aircraft. Examination revealed that the main landing gear pivot bearings had seized onto the shaft of the main gear mounting frame. CAA Closure: The hazard is adequately controlled by existing requirements, procedures and documentation.

AAIB Bulletin 2/2008, ref: EW/G2007/05/06 - Summary: At about 400 to 500ft agl the propeller became detached from the aircraft. The pilot made a 180deg turn and was able to land successfully on the reciprocal runway. Two 'half-rings' that retain the propeller shaft inside the gearbox werefound to have failed and the manufacturer is currently undertaking a detailed examination of these components. The half-rings had recently been replaced by an experienced engineer and hence incorrect installation would seem unlikely. This would appear to be an unusual failure and hence the components have been sent to the manufacturer for further analysis. This may take some time. Should further significant and relevant information be obtained by the AAIB, a supplementary report will be published. CAA Closure: No further CAA action is practicable at this time, however, onreceipt of any additional information, the CAA's records will be updated accordingly and the occurrence may be re-opened if further action is deemed necessary.
CAA Closure: The aircraft landed with the left main landing gear not fully down. Metallurgical examination showed that this was due to the separation of the landing gear pivot assembly which had resulted from a cyclic fatigue mechanism. There is a history of similar failures on the R182 and the 172RG which share a similar, but not identical, design of the pivot assembly to that of this aircraft. See AAIB Bulletin 8/2008, ref: EW/C2007/10/03.
This occurrence is subject to investigation by the British Gliding Association. On receipt of their report, the CAA's records will be updated accordingly and the occurrence may be re-opened if further action is deemed necessary.
AAIB Bulletin 1/2008, ref: EW/G2007/10/19 - Summary: The aircraft was intending to fly a 'touch-and-go', at a grassairstrip. During the ground roll, the pilot experienced atendency for the aircraft to yaw to the left (attributed to a deflated left tyre), which he overcame with right rudder. The aircraft got airborne at a lower speed than normal; it subsequently stalled and struck the ground. The aircraft was extensively damaged, but the pilot and his passenger escaped without injuries. CAA Closure: No CAA action appropriate.
AAIB Bulletin 3/2008, ref: EW/G2007/11/04 - Summary: The student pilot was on a solo navigation exercise during which he encountered carburettor icing. The engine ran increasingly rough on the application of the carb heat and so the student returned it to the cold setting before deciding to carry out a forced landing in a field. After touchdown the nose leg broke off and the aircraft nosed over, the pilot receiving minor injuries. CAA Closure: No CAA action appropriate.

Engine manufacturer to attend.
A Training Captain was conducting an Operational Proficiency Check (OPC); the pilot under training was required to demonstrate a clear area rejected take-off. The helicopterwas equipped with a Training Idle System (TIS) which was in use to simulate a failure of the left engine. The helicopter took off along Runway 16 at Aberdeen; at about 28kt the commander simulated a failure of the left engine and the take-off was rejected. The pilot flared the helicopter to reduce speed and descended towards the runway. As the collective control lever was raised to reduce the rate of descent, the overspeed protection system shut down the right engine. Rotor rpm (rrpm) decayed rapidly and the helicopter touched down firmly before rrpm could be restored. Theright engine freewheel unit had failed causing that engine to overspeed; this was contained by the overspeed protection system shutting down the engine. Four Safety Recommendations (2009-003 to -006) are made, one addressed to Eurocopter and three to the European Aviation Safety Agency (EASA). CAA Closure: The Recommendations made in respect ofthis occurrence are not addressed to the CAA and are to be actioned directly by the relevant bodies. No further CAAaction is practicable.
AAIB Bulletin 12/2007, ref: EW/G2007/09/16 - Summary: After turning onto the base leg at Deanland, the engine failed to respond to throttle inputs despite the use of carburettor heat. The aircraft made a forced landing in a field, losing its wings as it passed through a hedge. The probable cause of the incident was thought to be carburettor icing. After a recent cable replacement, the carburettor heat control protruded from the instrument panel by more than 25mm in the cold position. This probably prevented the air valve from reaching its fully hot position before the control reached its maximum travel, thus limiting its ability to prevent the formation or removal of ice within the carburettor. CAA Closure: No further CAA action practicable.
CAA Closure: The right gear leg fractured and collapsed after landing. The failure was attributed to incorrect material properties in the gear leg, probably introduced during heat treatment. The Light Aircraft Association (LAA) have been informed and will publish an article in their newsletter to highlight the importance of correct heat treatment for critical components. See AAIB Bulletin 7/2008, ref: EW/G2008/12/04.

CAA Closure: Following a normal touchdown with 'three greens' indicating that the landing gear was locked down, thenose landing gear (NLG) collapsed, causing both propellers and the aircraft's nose structure to contact the ground.No technical cause was determined for the collapse, although the NLG mechanism reportedly exhibited evidence of wear and a lack of recent lubrication. The aircraft had made approximately 45 flights since an Annual Inspection where a pivot bolt, which reportedly exhibited signs of wear, was recorded as having been changed in accordance with FAA Airworthiness Directive AD 2005-13-16. See AAIB Bulletin 6/2008, ref: EW/G2007/12/05.
The pilot and his passenger, who each owned a half-share in the aircraft, were making a short flight between two airfields about 4nm apart. As the aircraft joined the circuit to land, at a height of around 800ft, there was a 'bang'as the tailplane separated and fell to the ground. The aircraft became uncontrollable and descended into trees. Theoccupants survived the impact but both received serious injuries. The tailplane attachment lugs had failed in upload; the metallurgical evidence showed that a stress corrosion mechanism had been present. Two Safety Recommendations (2008-45 and -46) are made, addressed to the DGAC and aircraft manufacturer respectively. CAA Closure: The Recommendations made in respect of this occurrence are not addressed to the CAA and are to be actioned directly by the relevant bodies. No further CAA action is practicable.
CAA Closure: Shortly after touching down after a normal approach, the nose landing gear collapsed, causing substantial damage to the aircraft. It was established that the nose gear actuator locking lugs had failed, allowing the nose gear to unlock and collapse forward on touchdown. Evidence was found of pre-existing cracks in the locking lugs; however, it was not determined by what mechanism the crackshad propagated. See AAIB Bulletin 8/2008, ref: EW/C2007/12/11.

The aircraft, soon after take-off, suffered a partial loss of engine power. The pilot returned to the farm strip from which he had taken off, and attempted to land. However,the approach was made with a tailwind and the aircraft was too fast to land before the end of the runway. The pilotattempted a go-around but there was not sufficient enginepower available; the aircraft descended and landed in a field just beyond the end of the runway. The aircraft struck a large oak tree, the passenger-side harness mounting was disrupted and the passenger was fatally injured. The investigation found that the main fuel jet of the right carburettor had become obstructed by a corrosion fragment liberated from the carburettor bowl. The failure of the passenger's restraint was found to be due to the failure of the bond between the shoulder harness attachment fitting and the inner surface of the fuselage, to which it was secured. One Safety Recommendation (2008-029) is made to the enginemanufacturer. See AAIB Bulletin 11/2008, ref: EW/C2007/09/10. CAA Closure: The Recommendation made in respect of this occurrence is not addressed to the CAA and is to be actioned directly by the relevant body. No further CAA action is practicable.
Early in the ILS approach the autothrottle disengaged with the thrust levers in the idle position. The disengagement was neither commanded nor recognised by the crew and thethrust levers remained at idle throughout the approach. Because the aircraft was fully configured for landing, the airspeed decayed rapidly to a value below that appropriatefor the approach. The commander took control and initiated a go-around. During the go-around the aircraft pitched up excessively; flight crew attempts to reduce the aircraft's pitch were largely ineffective. The aircraft reached a maximum pitch of 44deg nose-up and the indicated airspeed reduced to 82kts. The flight crew, however, were able to recover control of the aircraft and complete a subsequent approach and landing at Bournemouth without further incident. Although the commander reported the event to the operator the following morning, his initial Air Safety Report (ASR) contained limited information and the seriousness of the event was not appreciated until the Quick Access Recorder (QAR) data was inspected on 4 October 2007. The aircraft was not subjected to an engineering examination to ensure its continued airworthiness and remained in service throughout this period. The investigation identified the following causal factors: 1) The aircraft decelerated during aninstrument approach, to an
CAA Closure: On landing the aircraft's nose gear collapsed. The pilot reports he had confirmed three green lights during gear extension and no gear unsafe warnings had been observed prior to touchdown. No failure of the gear could be identified by the repair agency after the incident. SeeAAIB Bulletin 4/2009, ref: EW/G2008/10/01.
CAA Closure: The single-engined aircraft suffered a powerloss at 200ft agl shortly after takeoff; the pilot attempted to return to the airfield, however the aircraft strucka mound short of the field. The pilot sustained a fractured spine. It was not possible to determine the cause of the power loss with any degree of certainty, but a fuel system problem seemed the most likely cause. See AAIB Bulletin08/2009, ref: EW/G2008/10/02.

CAA Closure: The aircraft was returning to Shoreham aftera short local flight. Following a normal approach it touched down briefly before bouncing and finally landing whereupon the left landing gear began to collapse. The aircraftveered off the left hand side of the runway and the rightlanding gear collapsed before coming to rest following a ground roll of approximately 50m. The pilot judged the landing had not been particularly firm despite the bounce. Itwas found that part of the underside of the tubular steelfuselage framework to which the landing gear had been attached had failed at a weld joint. Part of the fracture surface appeared darker than elsewhere indicating that that acrack in the weld had been present for some time. This area had been repaired following a previous accident at Staverton on 15 November 1986, when registered as G AYMA (occurrence 198603881 refers). See AAIB Bulletin 2/2009, ref: EW/G2008/10/06.
This occurrence is subject to investigation by the Spanish Authorities. On receipt of their report, the CAA's records will be updated accordingly and the occurrence may be re-opened if further action is deemed necessary.
A/c returning to departure airport due technical problem. CAA Closure: As the aircraft touched down on R/W26, an external fuel tank fell from its wing and landed on the grass to the South of the runway. The tank hit a runway edge light and damaged the runway surface. The tank was held onto the wing by an electromagnetic tank release unit. The jaws of the unit opened on touchdown releasing the tank. See AAIB Bulletin 5/2009, ref: EW/C2008/10/14.
CAA Closure: Shortly after take-off, the aircraft lost power and a forced landing was carried out. The aircraft struck a tree before landing heavily in a field causing substantial damage. No cause has been established for the powerloss. See AAIB Bulletin 7/2009, ref: EW/C2008/11/02.
CAA Closure: Whilst flying a routine training circuit, the occupants heard a loud bang as the landing gear extendedand the 'gear unsafe' warning light remained illuminated.When the aircraft landed, the left main gear leg collapsed and the aircraft departed the runway. It was later identified that the retraction fitting had failed. See AAIB Bulletin 6/2009, ref: EW/G2008/11/04.

CAA Closure: Shortly after take-off, when at approximately 200ft above ground level, the engine speed dropped to idle. The pilot lowered the nose of the aircraft to maintainflying speed and turned right to land in a suitable field. The aircraft cleared a sturdy barbed wire fence but, as the aircraft touched down, a cow ran under and struck the left wing, causing substantial damage to the aircraft. Thecow was apparently uninjured. The aircraft rolled to a halt and the two occupants, who were uninjured, vacated the aircraft normally. Investigation of the aircraft by a local engineer found corrosion debris in the carburettor floatbowl, and this appeared to have originated from within the float bowl itself. The fuel tank, fuel lines and fuel filter were found to be clean. It is likely that this debrishad blocked the carburettor jets, causing the reduction in power, as the engine ran normally once the debris had been removed. See AAIB Bulletin 12/2008, ref: EW/G2008/09/08. AAIB Bulletin 7/2009 contains an addendum to the original report, which states that further investigation by the operator found that both magnetos were faulty, one due to oil contamination and the other due to coil breakdown.
CAA Closure: During final approach at a height of about 300 feet the engine stopped almost immediately. The instructor realised that he could not glide to the runway so he carried out a sideslipping turn to the left to try and landcrosswind in a field immediately below and to the left ofthe final approach path. On landing the RH main wheel sunk into waterlogged ground and its axle sheared, resulting in the aircraft pitching forward, shearing the nosewheel fork and damaging the propeller. The aircraft remained upright and came to a rest in a very short distance. The instructor and student were able to exit the aircraft normally and there was no fire. The engine stoppage was the result of fuel exhaustion which was possibly caused by an abnormally high fuel flow due to contamination within the fuel, jamming a carburettor needle valve open. See AAIB Bulletin 08/2009, ref: EW/G2008/12/01.
CAA Closure: The aircraft had returned from a navigation exercise and made a normal approach to R/W05 at Upfield Airfield. On touching down, the nose landing gear collapsed rearwards, allowing the aircraft's nose to descend until the propeller struck the runway. The aircraft slid to a halt on the concrete surface, following which the occupants exited without difficulty. See AAIB Bulletin 5/2009, ref: EW/G2008/11/11.
CAA Closure: The aircraft lost power shortly after take-off and struck a hedge. The loss of power was probably caused by contamination of the fuel, which was of unknown age and origin. See AAIB Bulletin 4/2009, ref: EW/G2008/09/17.

CAA Closure: During initial climb after a normal take-off, the pilot heard the engine note change unexpectedly. Seeing a suitable field ahead, he elected to carry out a precautionary landing. The landing was uneventful until at a low speed, the left main landing gear wheel rolled into soft ground. Subsequent inspection showed that the stub axle had cracked. The pilot considered that the engine problem was caused by vapour lock, and following discussions with the engine manufacturer's agent, he re-routed the fuel line to the left side of the engine so that it ran behind, rather than in front of, the carburettor. The aircraft was inspected by a BMAA Inspector and returned to service. See AAIB Bulletin 2/2009, ref: EW/G2008/09/22.
AAIU Report Nr 2008-008 - Summary: While dealing with a perceived technical problem about 20 minutes flying time from Galway Airport, the pilot became unsure of his positionand requested a radar heading to Galway from Shannon Air Traffic Control (ATC). On arrival at Galway the pilot carried out a landing on Runway (RWY) 08, where the aircraft was observed by ATC to porpoise or bounce a number of times, before departing the runway near its end, onto an open grass area. While the aircraft was substantially damaged, the pilot and passenger were unhurt. The Airport Fire Services later towed the aircraft to the light aircraft apron. The investigation concluded that (a) the aircraft sustained extensive structural damage following a heavy landing onRWY 08 at Galway Airport, (b) probable cause of the accident was due to the pilot being distracted by the three earlier but unrelated events in the latter part of the flight, leading to his lapse of concentration on landing, and (c) contributory factor was the pilot's overall inexperiencein the operation of a multi-engined aircraft.
CAA Closure: The aircraft suffered an electrical problem shortly after take-off and the pilot decided to return to the airfield. When he selected the landing gear down, all of the electrical power was lost. He did not have any indications to confirm that the landing gear was fully down, so he operated the emergency lowering mechanism. Believing that the landing gear was now down and locked he attempteda landing, but during the subsequent ground roll the landing gear collapsed. The investigation established that theelectric motor was still connected to the gear operating mechanism and that this prevented the landing gear from being fully lowered. See AAIB Bulletin 7/2008, ref: EW/G2008/01/01.

CAA Closure: The flight crew experienced control difficulties during the descent, the reasons for which were not evident but are now suspected to be due to interaction with the autopilot and a lack of autopilot visual and aural annunciations. The subsequent approach and landing were conducted at speeds considerably higher than normal. Two contact breakers were found to have tripped, one of which protects the circuits for two avionics cooling fans and the second being the 'AC Switch'. Labelling of the latter CB switch was in a non-standard position. The autopilot computer was tested with no faults found but when tested in both thesubject aircraft and another aircraft of the same type, uncommanded roll inputs were experienced during ground testing. Prior to the flight, 'Doors Not Locked, caption had illuminated, resulting in the Flight Data Recorder failing to record any data during the flight due to the cabin doorsensor failing to indicate the doors were locked. Crew Resource Management issues were also considered to be a contributory factor. AAIB Bulletin 01/2010, Ref: EW/C2008/03/02.

CAA Closure: The aircraft departed Biggin Hill for a private flight to Pau, France but shortly after take-off initiated a return to Biggin Hill after reporting engine vibration. During the downwind leg for Runway 21, the aircraft descended. The flight crew reported a major power problem just before it struck the side of a house. An intense fire developed. None of the two flight crew and three passengers survived. □
The following contributory factors were identified: □
1. It is probable that a mechanical failure within the air cycle machine caused the vibration which led tothe crew attempting to return to the departure airfield. □
□
2. A missing rivet head on the left engine fuel shut-offlever may have led to an inadvertent shutdown of that engine. □
3. Approximately 70 seconds prior to impact, neither engine was producing any thrust. □
4. A relight attempt on the second engine was probably started before the relitfirst engine had reached idle speed, resulting in insufficient time for enough thrust to be developed to arrest theaircraft's rate of descent before ground impact. □
Three Safety Recommendations, nrs 2010-014 and 2010-15, addressed to the Federal Aviation Administration, and 2010-016 addressed to ICAO have been made.□
See AAIB Aircraft AccidentReport: 03/2010, Ref: EW/C2008/03/03.

CAA Closure: Whilst landing at Leicester Airport, the pilot was unable to obtain a green 'down and locked' indication for the right main gear, despite several reselections. During the landing roll the gear collapsed at relatively slow speed and with minimal damage. Examination of the aircraft showed that both main gear uplock rollers had seized and this has previously been recognised as a cause of maingear 'hang ups'. A similar accident to a Beech 360 Bonanza, G-CDJV has also been published. AAIB Bulletin 01/2010, Ref: EW/C2008/04/08.

CAA Closure: Whilst on approach, at 720ft agl, the RH engine ceased responding to autothrottle commands for increased power and instead the power reduced to 1.03 Engine Pressure Ratio (EPR). Seven seconds later the LH engine power reduced to 1.02 EPR. This reduction led to a loss of airspeed and the aircraft touching down some 330m short of the paved surface of the runway. The investigation identified that the reduction in thrust was due to restricted fuel flow to both engines. It was determined that this restriction occurred on the RH engine at its Fuel Oil Heat Exchanger(FOHE). For the LH engine, the investigation concluded that the restriction most likely occurred at its FOHE. However, due to limitations in available recorded data, it was not possible totally to eliminate the possibility of a restriction elsewhere in the fuel system, although the testing and data mining activity carried out for this investigation suggested that this was very unlikely. Further, the likelihood of a separate restriction mechanism occurring within seven seconds of that for the right engine was determined to be very low. The investigation identified the following probable causal factors that led to the fuel flow restrictions: 1) Accreted ice from within the fuel system (referring to the aircraft and engine fuel system
CAA Closure: On landing, both main landing gears retracted. Upon recovery of the aircraft, the master switch was selected on, following which the landing gear completed its deployment cycle and locked down; also, the green 'Gear Down' light illuminated. A visual check of the landing gear revealed no evidence of failure or defects, although at the time the aircraft was recovered, full functional testingcould not be carried out. Further to this accident and its investigation, the same a/c suffered a similar accident on 29 March 2009 (AAIB Bulletin 08/2010, Ref: EW/C2009/03/04). In this instance, the investigation revealed a technical problem in the landing gear system, See AAIB Bulletin 8/2008, ref: EW/G2008/04/07.
CAA Closure: The pilot/owner carried out a normal pre-flight check of the aircraft and found everything to be acceptable for flight. After starting the engine he ensured that it had reached its operating temperature, which took 8 to 9 minutes, before starting the take-off. At about 100ft on the climb-out, the engine 'faltered'. The pilot levelled the aircraft which was very rapidly followed by the engine stopping. He applied nose-down pitch and steered the aircraft away from the hangars and parked aircraft that werein the overshoot area of the runway. Due to insufficient height, speed and time the pilot initiated the flare as the aircraft impacted the ground in a field adjoining the side of the runway. Following the accident, the pilot could find no obvious reason for the engine failure. The engine was taken to the manufacturer's UK agent where it was examined and test run. The examination of the cylinders and pistons revealed no evidence of a 'cold' seizure. The enginewas placed onto a test stand and test run. It ran satisfactorily. The ground level temperature and humidity figuresfrom a meteorological aftercast were plotted on the carburettor icing probability chart, and they indicated that there was a possibility of moderate

CAA Closure: The microlight aircraft collided with a boundary fence during a forced landing in a field following anengine failure. The aircraft was extensively damaged and one pilot sustained minor injuries. See AAIB Bulletin 8/2008, ref: EW/G2008/04/11.
CAA Closure: After landing on the grass runway at ClactonAirfield the nose leg collapsed. The nose leg shaft had fractured due to fatigue cracking. See AAIB Bulletin 9/2008, ref: EW/G2008/04/13.
CAA Closure: The flight was planned as a refresher for the pilot under instruction who held a PPL. After carrying out a normal visual approach, in calm wind conditions, to Runway 26 at Alderney, the instructor stated that the subsequent landing was slightly heavier than normal. However, during the landing roll, the instructor noticed the aircraft begin to veer to the right. He took control and was ableto steer the aircraft onto the grass beside the runway. Both occupants exited the aircraft without difficulty. During the subsequent inspection, it was found that the right main landing gear oleo piston tube had fractured. Metallurgical examination showed that it had failed due to fatigue; the piston tube had been separated for some time as evidenced by debris and damage to the fracture surface. It is likely that the piston tube, having been failed at this location for some time had continued to operate normally within the shock strut. However, in this landing, the heavierthan normal touchdown had allowed the piston tube to rebound beyond the normal operating range, thus allowing the lower portion to separate. See AAIB Bulletin 9/2008, ref: EW/C2008/01/07.
Following an extended period of heavy rain, VP-CRC took off from a dry runway for a long range flight to London Luton Airport. During the subsequent landing roll, the LH inboard main landing gear tyre suffered a slide-through failure resulting from an initially locked wheel. This tyre failure caused extensive damage to the flight control system.Although the aircraft landed safely, the investigation revealed a significant flight safety risk and four Safety Recommendations were made: 2008-071 and 2008-072 addressed to the aircraft manufacturer; 2008-073 addressed to the FAA, EASA and Transport Canada; and 2008-074 addressed to theFAA and EASA. See AAIB Bulletin 12/2008, ref: EW/C2008/01/03. CAA Closure: The Recommendations made in respect of this occurrence are not addressed to the CAA and are to beactioned directly by the relevant bodies. No further CAA action is practicable.

CAA Closure: This was the aircraft's first flight following several months of storage. The pilot completed the pre-flight and power checks to his satisfaction and proceeded to take-off from Runway 10 at Clotton. Weather conditions at the time were good, with a light, variable wind. Shortly after take-off the rate of climb decreased and increasedpressure on the throttle lever had little effect. The aircraft reached a height of between 30 to 50ft before starting to descend and it subsequently collided with trees 150 metres beyond the end of the runway. The pilot, who was wearing a lap strap and a helmet, sustained minor injuries. Post-accident inspection of the engine revealed the presence of a greenish-grey deposit which was partially blockingone of the carburettor main jets. This appeared to be micro-bacterial in origin and had probably developed during the long period of storage. See AAIB Bulletin 1/2009, ref: EW/G2008/05/37.
CAA Closure: Shortly after take-off, the pilot noticed the engine was running roughly and that power was decreasingdespite full throttle being selected. As the aircraft wasunable to maintain altitude, a MAYDAY was declared and a forced landing was carried out in a field of standing crop. The aircraft sustained substantial damage in the landing, but both occupants were uninjured and able to leave the aircraft unaided. Weather conditions at the time were highly conducive to the formation of carburettor ice. See AAIBBulletin 8/2008, ref: EW/G2008/05/05.
CAA Closure: The tailwheel-equipped aircraft overturned on landing following the separation of the lower part of the right main landing gear. The cause of the separation could not be determined. See AAIB Bulletin 7/2009, ref: EW/C2008/06/03.
CAA Closure: On arrival overhead Lashenden, the pilot hadselected the landing gear 'Down'. The green 'Down and Locked' indications confirmed that the nose and LH main landing gears were correctly positioned, however, there was no green indication for the LH main landing gear. The pilot performed numerous landing gear retractions and extensions,high 'G' manoeuvres and emergency system extensions in order to attempt to lower the LH main landing gear, but without success. He then elected to carry out a wheels-up landing and alerted the emergency services. The pilot was uninjured and exited the aircraft without difficulty. Bird remains were found embedded in the LH gear uplock mechanism which had prevented the release of the uplock which was necessary in order to extend the gear. The main landing gear on the Yak 52 retracts forward. However, when retracted the legs remain exposed beneath the fuselage. The pilot commented that he had carried out a low, fast flypast at Headcorn prior to selecting the landing gear and, although he had not been aware of any birds, he considered that that the birdstrike was likely to have occurred during this manoeuvre. See AAIB Bulletin 8/2008, ref: EW/G2008/06/07.

CAA Closure: When the landing gear was selected DOWN, a loud mechanical noise was heard and no green landing gear 'down and locked' lights illuminated. The pilot recycled the landing gear twice and the nose and right landing gear 'down and locked' lights illuminated, but not the light forthe left landing gear. After two low flights past ATC thepilot was told that all three landing gear legs looked correctly extended, but towards the end of the landing roll the left landing gear collapsed. Components in the left landing gear system were found to be seized and restricted in movement. A similar accident, to a Beech 58 Baron, G-OSDI, has also been published. AAIB Bulletin 01/2010, Ref: EW/C2008/06/04.
CAA Closure: Towards the end of the landing run, a/c nosegear collapsed, the propeller hit the ground and the noseleg folded back under the fuselage. The fitting at the top end of the nose landing gear oleo had failed leaving thenose gear free to rotate backwards. The failure was caused by the growth of fatigue cracks weakening the fitting's attachment lugs which failed on this flight due to overload. See AAIB Bulletin 11/2008, ref: EW/G2008/06/27.
CAA Closure: During a training flight, three touch-and-golandings were conducted. The next landing was to be a full stop. However, on touchdown the aircraft veered to the right; the instructor took control and flew the aircraft off the ground. When the landing gear was subsequently retracted, an 'unsafe' indication was obtained and it was laterobserved that, with the gear extended, the left wheel appeared to be at 90 degrees to the airflow, with the leg deflected in an aft direction. The decision was made to return to the operator's base at Manchester, where, immediatelyprior to touchdown, both engines were shut down and the propellers feathered. Subsequent examination of the aircraft showed that the left landing gear forward trunnion fitting had broken into several pieces, thus releasing the leg from its location. Metallurgical examination indicated that the fitting had failed from a combination of loose attachment bolts and fretting damage. See AAIB Bulletin 12/2008, ref: EW/G2008/06/28.
CAA Closure: After a precautionary touchdown at his departure airstrip, due to suspicions about engine performance,the pilot decided to continue into a rolling take-off. During initial climb out the engine suffered a loss of powerand, in the subsequent forced landing, the aircraft hit atree before impacting the ground. The pilot and passengerwere uninjured but the aircraft was destroyed by fire. See AAIB Bulletin 2/2009, ref: EW/G2008/07/03.
CAA Closure: The aircraft inadvertently landed with the gear retracted, following a circuit breaker 'pop' in the landing gear electrical system. See AAIB Bulletin 2/2009, ref: EW/G2008/07/07.
CAA Closure: The aircraft departed the runway during landing due to the right landing gear outrigger failing to lock down. The reason for its failure to lock down could not be determined. See AAIB Bulletin 3/2009, ref: EW/G2008/07/12.

CAA Closure: The a/c was on a final approach to land on agrass runway when the engine began to run roughly. The pilot advanced the throttle which led to a marked reduction in power. The aircraft touched down on the grass short of the runway but was forced back into the air when it crossed the lip of a raised taxiway. During the following touchdown and deceleration, the left main gear was damaged and the propeller hit the ground before the aircraft came to a halt. The cause of the rough running and power loss was not positively determined at the time of publication of thisreport. See AAIB Bulletin 12/2008, ref: EW/G2008/07/24. The cause of the rough running and power loss, which occurred during this accident and had occurred before intermittently, had not been determined when the report was published. Subsequent investigation showed faults in both magnetossuch that when the generator windings became hot an electrical short developed. During testing, the left magneto failed completely after 20 minutes and the output from the right magneto became intermittent after 90 minutes. Both magnetos operated normally after cooling. AAIB Bulletin 08/2011.
CAA Closure: The right main landing gear failed to lock down after the landing gear was selected down on the approach to land. This resulted in the failure of a component inthe gear retraction/extension mechanism after landing, causing the right gear to partially retract. The right wingtip, flap, aileron and propeller contacted the runway and were damaged. The right gear was subsequently found to be stiff in operation; this was attributed to inadequate lubrication. See AAIB Bulletin 2/2009, ref: EW/G2008/05/19.
CAA Closure: Whilst taking off at a relatively high weight from an undulating grass airstrip, a partial failure of the wooden structure supporting the right main landing gear occurred. The aircraft climbed away safely and, after several low passes along the runway for observers to assess the damage, the landing gear collapsed when the aircraft landed. It was determined that the structure which failed had probably been weakened over a period of time by the aircraft's operation from the undulating grass surface of therunway at its home airfield. See AAIB Bulletin 1/2009, ref: EW/G2008/07/19.
CAA Closure: The aircraft landed heavily at Weston-on-the-Green and, after confirmation of damage to the right mainlanding gear, diverted for an emergency landing on the grass R/W21 at Oxford. Examination showed that the right gear shock absorber had separated from the main landing gear and the retaining nut showed no evidence of having been correctly wirelocked at maintenance, probably some years previously. See AAIB Bulletin 7/2009, ref: EW/C2008/07/08.

CAA Closure: The aircraft was operating a scheduled passenger transport flight with the nr2 air conditioning pack inoperative, as permitted by the Minimum Equipment List (MEL). Whilst en route, a failure of the nr1 Air Cycle Machine (ACM) occurred, releasing smoke and fumes into the aircraft. A MAYDAY was declared and an expeditious diversion was carried out. After donning oxygen masks the pilots had great difficulty communicating with each other, ATC and cabin crew, because of technical problems with the masks. During the emergency evacuation the RH overwing emergency exit door became jammed and unusable. Passengers who evacuated via the LH overwing exit were unaware of how to get fromthe wing down to the ground. Two Safety Recommendations, nr 2010-007 addressed to EASA and 2010-008 addressed to the aircraft manufacturer, are made as a result of this investigation. AAIB Bulletin 06/2010, ref: EW/C2009/03/03.
CAA Closure: During a normal landing, the right mainwheelseparated from the aircraft due to failure of the RH maingear stub axle. See AAIB Bulletin 09/2009, ref: EW/G2009/08/01.
CAA Closure: The pilot was forced to land the aircraft ina field after the engine failed to respond when he attempted a go-around manoeuvre. This was as a result of anotheraircraft turning on to final approach ahead of him, leaving insufficient separation for him to continue. The pilot was uninjured and the aircraft sustained minor damage. Theweather conditions were conducive to serious carburettor icing at descent power settings. See AAIB Bulletin 11/2008, ref: EW/G2008/08/10.
CAA Closure: The pilot was forced to land the aircraft ina field after the engine failed to respond when he attempted a go-around manoeuvre. This was as a result of anotheraircraft turning on to final approach ahead of him, leaving insufficient separation for him to continue. The pilot was uninjured and the aircraft sustained minor damage. Theweather conditions were conducive to serious carburettor icing at descent power settings. See AAIB Bulletin 11/2008, ref: EW/G2008/08/10.

CAA Closure: The aircraft suffered a loss of Engine Pressure Ratio (EPR) information for the left engine during thetake-off roll. The take-off was rejected at about 120kts.During the deceleration the brake reaction rod on the LH main rear (nr5) wheel was released from its mounting, the brake pack rotated and caused damage to the brake hydraulic lines. The aircraft was decelerated to taxi speed and taxied clear of the runway to a parking area. During taxi two tyres deflated and most of the contents of the green hydraulic system were lost. The investigation found that the pin attaching the brake reaction rod to the brake unit hadsuffered an overload failure; evidence suggested that it was in a weakened condition following an earlier, unidentified event. The EPR problem was the result of a failure ina pressure sensing tube that supplied the FADEC on the Nr1 engine. See AAIB Bulletin 11/2009, Ref: EW/C2008/05/04.
CAA Closure: During an approach to land at a farm strip, the engine reportedly lost power, resulting in the aircraft landing short in 'soggy' ground. The undercarriage became bogged down and the aircraft overturned, sustaining minor damage in the region of the cockpit aft bulkhead. On examining the engine, the pilot discovered a small crack in the right cylinder head, which he presumed had caused the power loss. See AAIB Bulletin 2/2009, ref: EW/G2008/05/34.
CAA Closure: The owner of the aircraft was undergoing type conversion training under the supervision of another pilot. A number of circuits were completed successfully, but on the final landing the landing gear collapsed. A steel tube was found to have failed. See AAIB Bulletin 9/2008, ref: EW/G2008/05/36.
AAIB Aircraft Accident Report 1/2006 - Summary: Shortly after take off from Guernsey Airport, a loud crack or bang was heard in the aircraft's cabin. The aircraft commander was told by a colleague in the cabin that one or more passengers had been injured and that a cabin window was broken. He decided to return to Guernsey Airport, having been airborne for approximately four minutes. After the passengers disembarked the pilot noticed that a de-icer boot had separated from the left hand propeller and was now on the seat inside the cabin, adjacent to the broken window. The investigation identified the following causal factors:- i) The accident was caused by the separation of a de-icer boot from the left propeller during take off; ii) The de-icerboot separated due to peel stresses generated by forces on the propeller. The peel stresses arose because of physical or contamination damage to the adhesive bond which occurred because the required filler material was not used at the root of the de-icer boot. Two Safety Recommendations (2005-78 and 2005-79) were made during the course of the investigation. CAA Closure: CAA FACTOR F1/2006, detailing the CAA responses to the two AAIB Safety Recommendations, was issued on 11 January 2006. Any further CAA action required will be progressed via the 'Annual Review of

AAIB Bulletin 7/2006, ref: EW/G2006/03/02 - Summary: Whilst at 1,000ft on the downwind leg of the circuit for Runway 02, the pilot experienced rapidly increasing airframe vibration; approximately five seconds later the engine stopped suddenly. The pilot noticed that the propeller was no longer attached to the engine and landed successfully on analternate runway. Investigation revealed that the loss ofthe propeller was due to the fatigue failure of the boltssecuring the propeller back-plate to the crankshaft. As aresult of this accident the engine manufacturer has incorporated a number of changes to the 'Mt' propeller installation for this engine type.
CAA Closure: The hazard is adequately controlled by the actions stated above.

AAIB Bulletin 7/2006, ref: EW/G2006/03/03 - Summary: Whilst carrying out a practise stall the engine began to misfire. Relevant cockpit actions did not cure the misfiring but the engine did start to run more normally during the recovery to Crowfield Airfield. The aircraft became high and fast on the approach and, when it was clear that a safe landing was unlikely, the pilot applied full power to go-around. As the aircraft turned downwind it was clear that theengine was not providing sufficient power to maintain height and speed so a forced landing was carried out into a field. The occupants received only minor injuries but the aircraft was extensively damaged during the landing.
CAA Closure: No CAA action appropriate.

AAIB Bulletin 06/2006, ref: EW/G2006/02/06 - Summary: During the approach a loud bang was heard by the aircrew, followed by a loss of the yellow hydraulic system. The aircraft landed safely whereupon a hydraulic accumulator was found to have burst. The failure was subsequently attributed to a material defect in the cylinder wall of the accumulator. No one was injured in the incident. A safety action plan is being put in place by the aircraft manufacturer, in conjunction with the accumulator manufacturer, to check those accumulators which might have similar defects. See also 200702595.
CAA Closure: The hazard is adequately controlled by the actions stated above.

AAIB Bulletin 12/2006, ref: EW/C2006/02/05 - Summary: This accident was the subject of AAIB Special Bulletin S2/2006. A propeller blade detached during a touch and go landing, leading to loss of the propeller and partial separationof the engine from the aircraft. An existing Manufacturer's Service Bulletin was identified as being relevant to the failure. Three Safety Recommendations (2006-46 to -48) were made, to the Civil Aviation Authority (CAA), the Federal Aviation Administration (FAA) and the European Air Safety Agency (EASA). Subsequent metallurgical analysis confirmed the cause as a fatigue failure. Since publication of the Special Bulletin, the CAA has issued a Letter to Operators on the subject and the FAA and the EASA have produced an appropriate Airworthiness Directive. See also AAIB Bulletin 1/2007, which contains a correction to the original report. CAA Closure: CAA FACTOR F50/2006, detailing the CAA responses to the three AAIB Safety Recommendations, was issued on 12 December 2006. Any further CAA action required will be progressed via the 'Annual Review of AAIB Recommendations' procedure.
Flypast inspection confirmed gear appeared down/locked. No injuries to 32 POB. Extent of damage unknown. This occurrence is subject to investigation by the Swedish Authorities. On receipt of their report the CAA's records will be updated accordingly and the occurrence may be re-opened if further action is deemed necessary.
This occurrence is subject to investigation by the Dutch Authorities. On receipt of their report the CAA's records will be updated accordingly and the occurrence may be re-opened if further action is deemed necessary.
AAIB Bulletin 8/2006, ref: EW/G2006/04/09 - Summary: After landing, with very little forward speed, the right wing dropped and the wing tip touched the ground. The attachment lug for the left side of the inverted 'A' frame landing gear support had failed, as a result of a fatigue mechanism, allowing the landing gear to collapse. CAA Closure: The hazard is acceptable provided the frequency of occurrence remains low.
AAIB Bulletin 7/2006, ref: EW/G2006/04/13 - Summary: The nose wheel collapsed following a normal landing. An examination of the aircraft after the accident revealed no obvious fault that would have prevented the landing gear from extending, or the indicating lights from illuminating. CAAClosure: No CAA action appropriate.
AAIB Bulletin 3/2007, ref: EW/G2006/04/16 - Summary: Whilst initiating the landing flare the dual cockpit control stick became disconnected from the flying control system and the aircraft pitched nose down, impacting the grass runway. Nose landing gear, propeller, engine mountings and cowling damaged. The investigation report issued by the AAIB contains two Safety Recommendations (2006-110 and 2006-111), both addressed to the kit manufacturer. CAA Closure: CAA FACTOR F12/2007 was issued on 11 April 2007.

AAIB Bulletin 9/2007, ref: EW/C2006/05/04 - Summary: The pilot reduced speed as he approached the airfield, and almost immediately experienced erratic power fluctuations. Hetherefore entered an autorotation and attempted to clear some trees on the approach to his chosen landing site. At about 40 to 50 feet above the ground, the helicopter descended rapidly and as a result landed heavily and rolled on to its side. The pilot was uninjured. The investigation could not identify the cause of the power fluctuations. CAAClosure: No further CAA action practicable.
AAIB Bulletin 9/2006, ref: EW/G2006/05/17 - Summary: Shortly after take off the engine failed and a forced landing was made in a field beyond the end of the runway. The aircraft landed heavily causing the nose gear to collapse and the aircraft flipped upside down. The engine failure was caused by excessive water in the fuel. It was not possible to determine how the water entered the fuel system but it is probable that the heavy rainfall during the week leading up to the accident flight, while the aircraft was parkedoutside, was a contributory factor. CAA Closure: No CAA action appropriate.
This occurrence is subject to investigation by the U.A.E.Authorities. On receipt of their report, the CAA's records will be updated accordingly and the occurrence may be re-opened if further action is deemed necessary.
AAIB Bulletin 3/2007, ref: EW/C2006/05/07 - Summary: After a normal touchdown on both main wheels followed by the nose wheel, the nose wheel shimmied and departed the aircraft together with the nose wheel fork. The lower cowl, propeller, nose gear leg, nose gear mount and main gear fairings were all subsequently damaged. The pilot and the passenger were uninjured. A scroll pin which retained the nose wheel fork assembly had failed, although the precise cause of this failure could not be determined. One Safety Recommendation (2006-146), addressed to the aircraft manufacturer, is made. CAA Closure: CAA FACTOR F18/2007 was issued on 10 May 2007.
AAIB Bulletin 5/2007, ref: EW/C2006/06/09 - Summary: Following a normal approach and touchdown a loud scraping noise was heard from the front of the aircraft, which was followed by the nosewheel detaching from the nose leg. The metallurgical examination revealed that both the nose landinggear wheel fork arms had failed in overload and that the materials were of the correct specification. See also 200509395. The investigation report issued by the AAIB contains three Safety Recommendations (2006-113, -114 and -115), which are addressed to the aircraft manufacturer and EASA. CAA Closure: CAA FACTOR F16/2007 was issued on 10 May 2007.

AAIB Bulletin 01/2008, ref: EW/C2006/06/05 - Summary: During the landing roll, the crew were unable to decelerate the aircraft sufficiently because they were unable, repeatedly, to select the power levers into the BETA range. The aircraft overran the runway and the Runway End Safety Area,coming to rest some 350 metres beyond the end of the runway. There were no injuries. During their investigation, the AAIB issued three Safety Recommendations. One (2006-104), addressed to the aircraft manufacturer, was published inSpecial Bulletin S7/2006 and the other two (2007-103 and 2007-104), addressed respectively to the aircraft manufacturer and EASA, in the final report.
CAA Closure: The Recommendations made in respect of this occurrence are not addressed to the CAA and are to be actioned directly by the relevant bodies. No further CAA action is practicable.

AAIB Bulletin. ref: EW/C2006/06/08 - Summary: The aircraft had just undergone a period of maintenance and was on its first flight after it had been completed. On take-off itbecame apparent that there was a problem with one or bothengines and the pilot, having got airborne attempted to return to the airfield. The aircraft bounced on landing andthe pilot attempted a go-around with the aircraft still at low speed. He then banked the aircraft steeply to the left shortly after which it is believed he lost directional control of the aircraft before then stalling at a height too low to be able to recover, the aircraft crashed and caught fire. As a result of a review of the accident report and associated aircraft/engine maintenance manuals, it is concluded that there are no outstanding maintenance issues associated with this incident. However, it is suggested that this accident report is referenced to, and summarised in, a future edition of GASIL, highlighting issues of 1) Fuel contamination, 2) Continuing airworthiness of 'inactive' aircraft, and 3) Handling of twin-engined aircraft with a defective engine.
CAA Closure: The hazard is adequatelycontrolled by the actions stated above

AAIB Bulletin 1/2007, ref: EW/G2006/07/06 - Summary: The pilot heard a loud bang during landing and carried out a go-around. He determined that the nose leg was unlocked andcould not be correctly locked down. Considerable damage was inflicted during the subsequent landing. Examination revealed that a bolt in the operating mechanism had failed, causing a change of geometry which allowed excessive loadsto be applied to the system, leading to further failure.CAA Closure: The hazard is acceptable provided the frequency of occurrence remains low.

AAIB Bulletin 11/2006, ref: EW/C2006/07/26 - Summary: Theengine failed shortly after take off and, in the ensuing forced landing, the aircraft stuck a fence and pitched inverted, causing minor injuries to the pilot and moderate damage to the aircraft. It was quickly established that the engine oil filter had become detached, allowing oil to escape and the engine to seize from oil starvation. The oil filter had been replaced the previous day with a 'FRAM' automotive oil filter, instead of the Rotax-approved part. The FRAM filter has a slightly larger diameter thread which makes it incompatible for use on this type of engine. Two safety recommendations (2006-107 and -108) were made, withthe intention of preventing similar accidents in the future. CAA Closure: CAA FACTOR F48/2006 was issued on 12 December 2006.
AAIB Bulletin 11/2006, ref: EW/G2006/07/32 - Summary: Shortly after taking off from RAF Syerston the pilot noticed that the engine was not running at maximum speed and, as the aircraft climbed through 200ft, it began running roughly with its speed decreasing. The pilot reduced the power setting, which resulted in the engine running smoothly for a short while but when increased power was demanded to initiate a climb and return to RAF Syerston, the engine againbegan to run roughly and failed to respond to throttle inputs. The pilot carried out a forced landing in a crop field which resulted in the collapse of the nose landing gearand damage to the lower fuselage and wing mounts. In the absence of any identifiable technical defect, it was considered that fuel vapour locking, caused by the use of un-insulated fuel lines within the engine compartment, had caused the loss of power. CAA Closure: No CAA action appropriate.
AAIB Bulletin 4/2007, ref: EW/G2006/07/10 - Summary: Following a normal landing, with a slight crosswind from the left, the left main landing gear failed at the shock strut end fitting. The aircraft came to a stop resting on the right main landing gear, the tail wheel and the left wing tip. Engineering investigation revealed that the incident was the result of progressive deformation of the end fittingbolt hole, which resulted in it failing in tensile overload. CAA Closure: No CAA action appropriate.
This occurrence is subject to investigation by the Singapore Authorities. On receipt of their report the CAA's records will be updated accordingly and the occurrence may be re-opened if further action is deemed necessary.

AAIB Bulletin 5/2007, ref: EW/C2006/08/02 - Summary: Whilst on a flight from Bucknall to North Coates, the aircraftwas nearing its destination when the pilot transmitted a radio call indicating that he had an elevator control problem. He attempted an immediate approach to the airfield, but, as he was too high, carried out an orbit before makinga second approach. On short finals, at a height of around150ft agl, the aircraft was seen to suddenly pitch nose down and impact the ground in a near-vertical attitude. Theinvestigation revealed that a nut and bolt attaching the tailplane bracing wires to the fin had come undone, resulting in what was effectively a structural failure of the tailplane. CAA Closure: No further CAA action practicable.
Pieces of turbine found on ground. Attributed to an HP1 turbine blade failure originating from an internal blade cavity. The crack initiation site was damaged due to post event impact and, therefore, the OEM has been unable to determine the root cause. This is, however, the first such reported failure due to this mechanism on this blade in 45,000,000 hours operation. The OEM has reviewed data from manufacture to determine if there has been some shift in manufacturing parameters, but no trend has been identified. CAA Closure: This occurrence is subject to investigation bythe French Authorities (BEA). On receipt of their report,the CAA's records will be updated accordingly and the occurrence may be re-opened if further action is deemed necessary.
This occurrence is subject to investigation by the FrenchAuthorities. On receipt of their report the CAA's recordswill be updated accordingly and the occurrence may be re-opened if further action is deemed necessary.
AAIB Bulletin 2/2007, ref: EW/G2006/08/06 - Summary: The aircraft suffered a loss of engine power shortly after take off but the instructor pilot was able to land back on the runway. However, there was insufficient distance available in which to stop and the aircraft overran the end of the paved surface and passed through the airport boundary fence, coming to rest inverted on a public road. Although itwas substantially damaged and leaking fuel, there was no fire. Examination and testing of the engine and other components did not identify any defects that could have accounted for the loss of engine power. CAA Closure: No CAA action appropriate.

See AAIB Bulletin 4/2007, ref: EW/G2006/09/06.
CAA Closure: No CAA action appropriate.

AAIB Bulletin 8/2007, ref: EW/C2006/09/08 - Summary: After conducting a short local flight, the pilot flew the aircraft back to the departure airfield to carry out some 'touch-and-go' landings. During the climb out from the second take-off, following a normal touchdown and landing roll, the nose landing gear fell away from the aircraft. A metallurgical examination revealed fatigue crack growth in the nose landing gear outer tube. It was not possible to establish the length of time that the fatigue cracking had been present prior to the final failure. The nose landing gear had been fitted to the aircraft as a replacement item some51½ airframe hours prior to this accident. The investigation report issued by the AAIB contains two Safety Recommendations (2007-038 and -039).
CAA Closure: CAA FACTOR F32/2007, detailing the CAA responses to the two AAIB Safety Recommendations, was issued on 13 September 2007. Any further CAA action required will be progressed via the 'Annual Review of AAIB Recommendations' procedure.

AAIB Bulletin 7/2007, ref: EW/C2006/09/07 - Summary: Whilst in the approach phase of a night currency flight, the aircraft suffered a sustained loss of engine power that required the pilot to make a forced landing. In the darkness,the pilot was unable to locate a clear area in which to land and the aircraft flew into a tree, where it came to rest. Shortly afterwards the aircraft caught fire and the pilot, unable to open the aircraft's door, vacated the aircraft through a perspex window. He fell to the ground and was taken to hospital with serious burn injuries. Examination of the engine found no evidence of mechanical failure. It was noted that the prevailing atmospheric conditions were conducive to the formation of serious carburettor icing in the descent, although the carburettor heat selector wasfound in the 'ON' position.
CAA Closure: No CAA action appropriate.

AAIB Bulletin 3/2008, ref: EW/G2006/12/08 - Summary: During taxi prior to flight, the engine cowlings from the nr3 engine detached, causing minor damage to the fuselage and the nr4 propeller. The flight proceeded uneventfully and their loss was only discovered after the aircraft's arrivalat its destination; the doors were discovered on a taxiway at the departure airfield. The investigation concluded that the nr3 engine air turbine starter motor casing probably failed after engine start, releasing a rotating clutch assembly into the nacelle, which caused deformation to oneof the cowling doors. This in turn, allowed propeller wash to enter the nacelle and overstress the door latches attachment structure. Only approximately half of the casing fragments were recovered but none showed any evidence of pre-existing cracking or other defects. The operator, to whom the L188 aircraft type is unique in the UK, has instituted regular inspections of the starter motors to check for defects/cracks.□
CAA Closure: The hazard is adequately controlled by the actions stated above.

CAA Closure: The a/c was departing from R/W14 for a flight to oil platforms in the North Sea, carrying 13 passengers. Five seconds into the takeoff the crew heard a bang andan abnormal vibration started. The crew rejected the take-off and landed back on the runway. The a/c started to taxi but the severe vibration continued so the commander stopped and shut down the helicopter on the threshold of R/W32. Initial examination showed that one main rotor blade spindle had fractured, through the lower section of its attachment yoke on the leading side of the spindle. Post-fracture plastic deformation of the lug had stretched open the fracture, separating the faces by some 12mm. As a result ofthis accident, the helicopter manufacturer published an Emergency Alert Service Bulletin, requiring periodic inspections, and this was subsequently mandated by the European Aviation Safety Agency (EASA) as an Airworthiness Directive. In July 2009 the manufacturer issued Service Bulletins which introduced a 'wet' assembly procedure, with new nuts, for the main rotor blade spindles. This eliminated the requirement for the repetitive inspection procedure and wasmade mandatory by the issue of an Airworthiness Directive(AD) by the EASA. The investigation identified the following causal factors for the

AAIB Bulletin 3/2007, ref: EW/G2006/10/07 - Summary: After a normal touchdown the nose landing gear failed. The separation resulted from fatigue damage induced by cyclic bending due to normal operating loads on the landing gear.□
CAA Closure: The hazard is acceptable provided the frequency of occurrence remains low.

AAIB Bulletin 3/2007, ref: EW/G2006/10/08 - Summary: Whilst taking off from a grass airstrip, the aircraft's enginefailed just as it became airborne. The pilot failed to maintain airspeed and the right wing dropped, touching the ground, resulting in a 'cartwheel'.□
CAA Closure: No CAA action appropriate.

AAIB Bulletin 2/2007, ref: EW/G2006/09/27 - Summary: After landing, when the nosewheel made contact with the ground, the aircraft veered uncontrollably to the left. The aircraft struck a low grass bank, damaging the propeller and fuselage, causing the nose and left landing gear to break off. Both the pilot and passenger were uninjured. An examination of the aircraft immediately after the incident showed that the LH landing gear attachment bolt had failed at the location of a pre-existing crack, associated with an area of bolt deformation. CAA Closure: The hazard is acceptable provided the frequency of occurrence remains low.
This occurrence is subject to investigation by the British Gliding Association. On receipt of their report the CAA's records will be updated accordingly and the occurrence may be re-opened if further action is deemed necessary.
AAIB Bulletin 2/2007, ref: EW/G2006/12/01 - Summary: The aircraft suffered a partial power loss after take off. During the subsequent forced landing on soft terrain, the aircraft sustained damage. The pilot attributed the cause of the power loss to carburettor icing. CAA Closure: No CAA action appropriate.
CAA Closure: Taking off from London Heathrow, both stick shakers began to operate continuously shortly before V1. The commander elected to continue the take-off and, after aperiod of troubleshooting in the air, dumped fuel and returned to land at Heathrow. Maintenance engineers consultedthe aircraft BITE (Built-In Test Equipment) and replaced the right-hand ADC (Air Data Computer). The subsequent take-off proceeded normally until approximately 5kt before V1, when the stick shakers again began to operate. The commander immediately rejected the take-off and the aircraft was stopped safely approximately two-thirds of the way alongthe runway. There was no damage or injury. This report includes a number of Safety Actions implemented by the operator and the aircraft manufacturer. See AAIB Bulletin 8/2008, ref: EW/C2006/12/01.

AAIB Bulletin 7/2007, ref: EW/G2006/12/05 - Summary: After take-off from St Mawgan the flight crew were informed byATC that a main wheel had fallen from the aircraft. The aircraft returned to St Mawgan and landed uneventfully. Thewheel was released due to a failure of the wheel bearing,but only a limited amount of the failed bearing was recovered. The failure mode of the bearing was not determined. The aircraft manufacturer has investigated several other such events and, as a result, introduced several measures to improve the durability of the bearing. CAA Closure: Thehazard is adequately controlled by the actions stated above.
AAIB Bulletin 03/2008, ref: EW/C2006/12/08 - Summary: During the landing roll, in a strong crosswind, the aircraft's rudder hardover protection system (RHPS) tripped, which resulted in the loss of both rudder hydraulic systems and reversion to the rudder's mechanical mode. The commander was able to maintain directional control using a combination of asymmetric braking and rudder. The RHPS was unnecessarily triggered in this event as no fault with the aircraftwas found. High rudder or brake pedal force application by the commander or incorrectly adjusted pedal force microswitches may have triggered the RHPS. The operator is planning on checking the pedal force microswitches during the aircraft's next base maintenance. A Safety Recommendation (2007-112) was made to the manufacturer concerning the design of RHPS. See also 200700214. CAA Closure: The Recommendation made in respect of this occurrence is not addressedto the CAA and is to be actioned directly by the relevantbody. No further CAA action is practicable.
AAIB Bulletin 3/2008, ref: EW/G2006/10/24 - Summary: A failure of the poorly maintained engine shortly after take-off resulted in damage to the aircraft during the subsequent forced landing. The cause of the failure was not identified. CAA Closure: No further CAA action practicable.
CAA Closure: Shortly after a normal take-off, at a heightof between 400ft and 700ft, the aircraft was seen to enter a steep left turn. When asked by the AFIS(O) what his intentions were, the pilot responded with a MAYDAY transmission, stating that he intended to land back at the airfield. After starting to turn to line up with R/W36, the aircraft was seen to enter a spin to the left and strike the ground. It was determined that a fault existed within the carburettor air heat mechanism which, under the prevailing conditions, may have led to a loss of engine power due to serious carburettor icing. AAIB Bulletin 12/2009, Ref: EW/C2009/02/07.

CAA Closure: The aircraft's engine suffered a loss of power in flight. During the subsequent forced landing the right main landing gear sheared off and the aircraft rolled inverted, sustaining extensive damage. The pilot escaped with minor injuries and there was no fire. It transpired that the power loss was caused by one of the spark plugs becoming unscrewed from the engine's front cylinder. See AAIB Bulletin 7/2009, ref: EW/G2009/02/06.
CAA Closure: The pilot attempted a forced landing as a result of a loss of power. The aircraft undershot the intended landing site and passed through two hedges and a road between before coming to rest in a ditch. It is thought theloss of power was most likely caused by carburettor icing, although a technical failure could not be ruled out. SeeAAIB Bulletin 09/2009. Ref: EW/G2009/02/09.
CAA Closure: The aircraft tipped forward onto its nose whilst landing on R/W20 at North Weald. The pilot, who was uninjured, reported that the approach and touchdown in a three-point attitude, were normal. When the mainwheels contacted the runway, the aircraft's tail lifted uncontrollably, causing the propeller to strike the ground. The pilot was able to maintain the runway centreline. Subsequent inspection of the pneumatically-operated wheel brake system suggested a defect in a brake control valve. The valve was removed from the aircraft but no faults were found. Despite further testing, it has not been possible to identify the cause of the reported partial brake application. The aircraft has since flown for several hours with no further braking problems. See AAIB Bulletin 7/2009 and 4/2010, ref: EW/G2009/03/04.
CAA Closure: The aircraft suffered an engine failure during a long final approach, due to suspected carburettor icing. The proximity of an operational power station and a broken electrical lead for the electric carburettor heat were considered to be significant factors. AAIB Bulletin 11/2009, Ref: EW/G2009/03/15.
CAA Closure: Internal corrosion of the RH main landing gear oleo shock strut had limited its free movement, such that landing gear was able to retract, but not extend. The aircraft landed with the right gear in the retracted position. See AAIB Bulletin 08/2009. Ref: EW/G2009/04/01.

CAA Closure: The pilot made a visual overhead join for entry into a RH circuit for R/W26. On the downwind leg he extended the landing gear and observed that the 'Down and Locked' light illuminated and checked visually that the landing gears were extended. On final approach the pilot checked that the green 'Down and Locked' light was illuminated.On touchdown, which was gentle, the main landing gears folded rearwards and the a/c came to a halt with the nose landing gear extended. The green 'Down and Locked' light wasstill illuminated. An engineering examination found that both main landing gear 'Down and Locked' magnetic proximity switches were stuck in their 'Down and Locked' positionsdue to a lack of lubrication and weak return springs. Twosafety recommendations, nrs 2010-050 and 2010-051, both addressed to the a/c manufacturer, are made. AAIB Bulletin 08/2010, Ref: EW/C2009/03/04.
CAA Closure: During a normal touchdown, the nosewheel steering connecting rod fractured at its attachment to the steering arm, due to abnormal bending loads caused by the seizure of a bush in its end-fitting. The aircraft yawed violently to the left, prompting an immediate go-around, during which the nosewheel was observed from the ground to be offset by about 45deg. During the subsequent landing, the aircraft again veered left and struck a runway light, causing minor damage to the right wheel door. See AAIB Bulletin 10/2009, ref EW/G2009/04/10.
CAA Closure: During a cross country flight, the engine started to run roughly and would not produce full power. Thepilot elected to land at a disused airfield but, after a normal touchdown, the pilot saw a fence across the runway which she was unable to avoid. The weather conditions wereconducive to carburettor icing and the pilot assessed this as the most likely cause of the power reduction and rough running. See AAIB Bulletin 08/2009, ref: EW/G2009/05/12.
CAA Closure: During the landing, the aircraft arrived over the runway threshold at 100 KIAS and then the pilot reduced the power and flared slightly. He stated that the aircraft made a harder landing than normal but not "over-hard"and then rolled normally along the runway. After a groundroll of about 300ft the pilot looked to his right and then moved his hand to turn off the fuel pumps. At about the same time he became aware of a sinking feeling which continued until the aircraft was sliding along the runway on its belly. When the aircraft came to a rest, both the pilot and passenger were able to exit via the main door. An examination of the aircraft did not reveal any damage that would explain a gear collapse, and therefore it was probable that the gear had retracted although there was insufficient information available to determine why this had happened. AAIB Bulletin 11/2009, Ref: EW/G2009/05/31.

CAA Closure: During the first operation following routineengine maintenance, the pilot flew a number of touch-and-go circuits, before conducting a local flight in the vicinity of the airfield. On his return, he completed a standard overhead join and commenced his descent to circuit height on the dead side of the runway. Half-way through the descent, the pilot applied power to warm the engine. On reaching the required height of 600ft he levelled out, but noted the engine was slow to accelerate again. As there was other traffic in the circuit the pilot elected to continue, but on base leg the engine started to fade and then stopped. The landing site options were limited, so the pilot chose the field with the least dense crop cover. He manoeuvred into the flare as slowly as possible, but the vegetationcaused the trike to pitch forward onto the nose gear, bending it at a welded joint. The aircraft came to rest without injury to the pilot. No causal defects were identified during repair of the aircraft. The pilot reported that theatmospheric conditions were conducive to carburettor icing, but added that this engine and installation were not particularly prone to the problem. AAIB Bulletin 11/2009, Ref: EW/G2009/06/20.
CAA Closure: After taking off from R/W09, at a height of 350ft, the engine lost power and began to run roughly. Dueto unsuitable terrain ahead, the pilot initiated a 180degturn to land back on R/W27. During the turn the pilot applied carburettor heat and changed fuel tanks, but with no effect on the rough running engine. He made a downwind flapless landing but was unable to slow the aircraft significantly before reaching the boundary fence. The aircraft was, however, travelling with sufficient speed to allow the pilot to 'hop' over the fence, touching down in a fenced compound beyond. It was brought to a halt when it struck thefence on the opposite side of the compound. The pilot wasuninjured. The cause of the loss of engine power has not been determined but the weather conditions for the day (temperature 24deg C and a dew point of 17degC) were conducive to moderate carburettor icing at cruise power/serious icing at descent power. The pilot commented that the pre-takeoff application of carburettor heat may have been insufficient to clear any carburettor ice that may have formed during taxiing. AAIB Bulletin 11/2009, Ref: EW/G2009/06/23.
CAA Closure: The aircraft suffered a loss of engine powershortly after take-off and crashed in a built-up area. The two occupants received minor injuries, but no one on theground was injured. No mechanical defects were found during strip examination of the engine. There was insufficientevidence to establish the cause of the loss of power, butan interruption in the fuel supply is believed to be the most likely cause. AAIB Bulletin 06/2010, Ref: EW/G2009/06/06.
CAA Closure: After touching down from a normal approach, the pilot was unable to prevent the aircraft from veering to the left and colliding with a hedge. Although no defects could be found with the tailwheel assembly, it was possible that, on takeoff, the wheel had disengaged from its detent connecting it to the rudder and that a misaligned operating spring had become foreshortened, biasing the wheel to the left. AAIB Bulletin 12/2009, Ref: EW/G2009/07/02.

CAA Closure: The aircraft was taking off from R/W23 in good weather conditions. Its initial climb was described by the pilot as normal until, at a height of about 250ft, theengine faltered but continued to run. The pilot judged that there was insufficient runway ahead to land safely and that the field beyond was unsuitable, as it contained highstanding crops in which the aircraft might turn over. He managed to gain some height and selected a short mown field to the right of the field of crops. He turned towards itand thought that he had cleared a tree in the undershot, when the engine lost all power. He lowered the nose of theaircraft to maintain flying speed, the aircraft struck the tree and became lodged in it. The pilot and his passenger unstrapped and climbed down from the tree, uninjured. The aircraft was extensively damaged but there was no fire. At the time of writing, neither the pilot nor his maintenance organisation had determined the cause of the engine problem. AAIB Bulletin 11/2009, Ref: EW/G2009/07/03.
CAA Closure: The aircraft was on the downwind leg of the circuit after a one hour flight when smoke began to enter the cockpit, coupled with a strong smell of burning wood. The crew saw that a small hole in the cockpit floor had formed, approximately 30mm in diameter, between and just aftof the rudder pedals. The edges of the hole were glowing and sparks were entering the cockpit. A MAYDAY call was transmitted and the aircraft made an expeditious landing with the airfield Fire and Rescue Service in attendance. During the final approach, the amount of smoke generated reduced and by the time the aircraft had completed its ground roll, the glowing around the edge of the hole had ceased. Amodification to the exhaust system, approved by the LightAircraft Association (LAA), had been made to improve the silencing of the engine. The original exhaust system consisted of four stub pipes exhausting below the cowling. An inspection of the aircraft confirmed that a hole in the modified exhaust system had allowed hot gases to impinge on the lower fuselage, which had led to the eventual 'burn through' of the cockpit floor. There have been no other reported incidents of this nature resulting from this modification but the LAA will be reviewing the modification to determine if any changes are
CAA Closure: During take-off the engine stopped suddenly,resulting in the aircraft landing back on the runway but then overrunning the end of the runway and entering a dyke. The reason for the sudden loss of the engine was most likely due to fuel vapour lock. The aircraft's fuel tank, made of metal and painted black, had been fuelled with MOGASand prior to the flight the pilot had parked the aircraftin a sunny spot, with the ambient air temperature at about 20deg C. AAIB Bulletin 12/2009, Ref: EW/G2009/08/08.

CAA Closure: While returning to land the pilot discoveredthat the nose gear leg would not extend. He carried out aseries of manoeuvres to try and free the nose gear leg, but the nose gear remained retracted. After declaring an emergency the pilot carried out a landing and held the nose of the aircraft off as long as possible until the propeller finally struck the ground and the aircraft came to rest.The fault was attributed to the right nose gear door jamming on its hinge. AAIB Bulletin 02/2010, Ref: EW/G2009/08/19.
CAA Closure: After a normal landing on a grass airstrip, the aircraft veered to the right and departed the right side of the runway. It struck a fence at slow speed and sustained damage to its propeller, forward fuselage, both wings and the right main landing gear. The pilot, who had beenunable to correct the aircraft's turn to the right, reported that the cross strut on the right main landing gear had failed, probably during the landing, altering the landing gear's geometry. He was unable to explain the cause of the failure but did not consider that it was a result of the landing, which had been normal. AAIB Bulletin 03/2010, Ref: EW/G2009/08/27.
CAA Closure: The canopy detached just as the pilot rotated the aircraft during takeoff. He abandoned the takeoff and vacated the runway. AAIB Bulletin 02/2010, Ref: EW/G2009/09/10.
CAA Closure: Shortly after take-off, at a height of approximately 100ft, the engine stopped. The pilot carried out a forced landing, and in an attempt to avoid a high hedge,he landed with a high vertical descent rate and low forward speed. The aircraft sustained damage but the pilot was uninjured. The pilot's post-accident examination of the engine and fuel system did not reveal any faults so the pilot considered that the engine may have suffered from carburettor icing. AAIB Bulletin 02/2010, ref: EW/G2009/09/14.
CAA Closure: The aircraft was on approach to Cambridge Airport. When the pilot selected the landing gear down, the gear down green light did not illuminate. The control tower confirmed that the nose gear had not deployed. The pilotfollowed the emergency procedures in the Pilot's Reference Handbook, which included use of the hand pump, but was still unable to deploy the nose gear. He made a MAYDAY calland landed on R/W10, which is grass. The aircraft settledonto its nose, resulting in damage to the propeller and forward fuselage. The pilot was unable to identify why the nose gear failed to deploy, but intends to have the nose gear actuator overhauled and to replace the hydraulic hoses. AAIB Bulletin 05/2010, Ref: EW/G2009/10/15.

CAA Closure: The aircraft had just become airborne when the engine lost power. A forced landing in a field resultedin a ground loop and collapse of the nose landing gear. AAIB Bulletin 04/2010, ref: EW/G2009/10/08.
CAA Closure: The aircraft impacted the aerodrome boundaryafter take-off was aborted following an apparent loss of engine power. Mechanical inspection did not determine the cause but reports of similar occurrences indicate that carburettor icing or rich cut were possibilities. The aircraft hit a dog as it came to rest and consideration is given to relevant aspects of aerodrome licensing. AAIB Bulletin 04/2010, Ref: EW/G2009/10/17.
CAA Closure: During the take-off roll, after passing V1 decision speed, the flight crew heard a "large thud", whichwas followed by moderate lateral vibrations and vibrations felt through the control column and rudder pedals. The flight crew continued the take-off and landed safely at their destination. An investigation revealed that the Nr14 tyre had burst during the take-off ground roll at approximately 160kts. The evidence indicated that the tyre probably burst when it ran over a foreign object. However, no foreign object was found and due to the missing tyre material, the nature of this object could not be determined. AAIB Bulletin 11/2010, Ref: EW/C2009/10/04.
CAA Closure: When the pilot initially lowered the landinggear, the green 'down-and-locked' light did not illuminate; this was due to a misaligned downlock microswitch on the LH main landing gear. The pilot operated the emergency hand pump to manually extend the gear but on landing, the nose leg collapsed. No other faults were found with the landing gear system. It is possible that during the manual extension there was insufficient pressure applied to fully lock down the nose leg. AAIB Bulletin 04/2010, Ref: EW/G2009/10/20.
CAA Closure: When the pilot initially lowered the landinggear, the green 'down-and-locked' light did not illuminate; this was due to a misaligned downlock microswitch on the LH main landing gear. The pilot operated the emergency hand pump to manually extend the gear but on landing, the nose leg collapsed. No other faults were found with the landing gear system. It is possible that during the manual extension there was insufficient pressure applied to fully lock down the nose leg. AAIB Bulletin 04/2010, Ref: EW/G2009/10/20.

CAA Closure: Immediately after touchdown, following a normal glider aerotow flight, the pilot heard a 'bang' from the left side of the aircraft and thought the noise was associated with the landing gear. He then switched the magnetos to 'Off' and attempted to hold the LH wing off the ground for as long as possible. However, as the aircraft slowed the left wing dropped and its tip contacted the damp grass runway surface; the aircraft slowly turned through 180degs before coming to rest. The pilot vacated the aircraft without difficulty. Post-accident inspection revealed the eye-end attachment lug on the LH landing gear damper unit had failed; such a failure allows the landing gear to be unrestrained and pivot outboard. It was evident from the fracture surfaces that the eye-end had been cracked for sometime before finally failing on this landing. The pilot reported that the aircraft was used exclusively for aerotowing operations and averaged some six flights per hour from a grass runway. AAIB Bulletin 04/2010, Ref: EW/G2009/10/24.
CAA Closure: Following retraction of the landing gear after take-off, the red gear unsafe warning light remained 'On'. When attempting to extend the gear again at the end ofthe flight, the nose landing gear did not fully deploy. When the a/c landed the nose gear collapsed, causing damageto the a/c nose and propellers but no injuries to the occupants. The nose gear drive chain was subsequently found to have failed in overload. AAIB Bulletin 11/2010. Ref: EW/G2010/11/11.
CAA Closure: Following an uneventful flight, the student pilot began a glide approach toward R/W28. The approach was normal but when the aircraft touched down, there was a noticeable airframe vibration. The instructor took control of the aircraft and applied full engine power in an attempt to go-around. As the aircraft pitched up it rolled to the right and the instructor applied left aileron to compensate; he later described the aircraft's response as 'sluggish'. The aircraft then rolled and yawed slowly to the left. It appeared to the instructor that the aircraft was not responding to control inputs, so he aborted the take-off. The aircraft's left wing then contacted the runway, followed by the left main wheel and then the right main wheel, before the aircraft departed the runway surface to the right and came to rest. There was no fire. The student pilot and instructor were uninjured and they were able to exit the aircraft normally. A subsequent examination of the aircraft did not reveal any pre-existing defects with the flying controls and the airframe vibration was determined to bedue to nosewheel shimmy. AAIB Bulletin 04/2010, Ref: EW/G2009/12/09.

CAA Closure: Following a pre-flight inspection, during which a small quantity of water was found in the LH fuel tank, the aircraft took off and the landing gear was retracted. At about 50ft, the engine lost power and the pilot madea forced landing on an adjacent grass runway but had insufficient time to lower the landing gear. Subsequent maintenance activity identified a loose-fitting filler cap on the LH fuel tank and a significant quantity of water also present in that tank and throughout the fuel system. No water was found in the RH fuel tank. Since its previous uneventful flight the aircraft had been parked outside for aboutthree weeks, during which the weather conditions had included snow and rain. AAIB Bulletin 04/2010, Ref: EW/G2009/12/15.
CAA Closure: The a/c's engine stopped without warning at a height of approximately 700ft during the climb after take-off. The pilot attempted to land back on the grass runway in the direction of take-off but there was insufficient height remaining to make the final turn and so he landed across the threshold, perpendicular to the runway. On realising that the a/c was likely to collide with a fence, he pushed the control bar forward to become airborne again andclear the fence. The back wheels of the trike struck the top of the fence as the a/c passed over it and the a/c dropped into the adjacent field, coming to rest on its side. The pilot considered that the most likely cause of the engine failure was either carburettor icing or ice in the fuel line. AAIB Bulletin 05/2011, Ref: EW/G2011/01/03.
CAA Closure: The pilot experienced difficulties with radio communications during the flight and was forced to divert to Jersey due to poor weather at his intended destination of Guernsey. The LH landing gear collapsed during the landing at Jersey. It was determined that the a/c had been unused for an extended period prior to the flight and that the landing gear pivot bearings were lacking in lubrication. AAIB Bulletin 07/2011, Ref: EW/G2011/02/01.
CAA Closure: After landing in strong and gusty wind conditions, damage was found to the a/c's LH Main Landing Gear.It was determined that the gear outboard trunnion pin hadfailed in overload due to upward loading on the outboard wheel. AAIB Bulletin 10/2011, Ref: EW/C2011/02/01.

CAA Closure: During circuits, the a/c landed in what was described as a "slightly flat and firm" touchdown, following which the nose landing gear immediately retracted. The nose dropped, causing the propellers to contact the runwaysurface and the a/c subsequently came to a halt further down the runway. Neither occupant was injured. The retraction may have occurred as a result of a slight 'out-of-rig' condition, although possible damage arising from an earlier heavy landing could not be ruled out. However, the PA-34series of a/c has a history of nose landing gear collapses, with no single cause having being identified although there are a number of potential contributory factors. The a/c manufacturer has introduced a number of measures, including a Service Bulletin, which has served to reduce the rate of this type of occurrence. AAIB Bulletin: 07/2011, Ref: EW/G2011/03/08.
CAA Closure: On final approach to his intended destination, the pilot selected the landing gear to the 'Down Locked' position but it failed to extend fully. The a/c divertedto an alternate airport and landed with the landing gear partially extended, resulting in damage to the a/c but without injury to the pilot or passengers. Hydraulic fluid leaking from a failed hydraulic hose prevented the landing gear from operating normally. AAIB Bulletin 08/2011, Ref: EW/G2011/04/02.
CAA Closure: The pilot selected the landing gear down when late downwind and observed a red light, which indicates that the gear is in transit but did not check for "three greens". The a/c landed gear-up on the grass runway. The pilot subsequently found that the circuit breaker for the landing gear had tripped. AAIB Bulletin 09/2011, Ref: EW/G2011/04/12.
CAA Closure: The a/c was landing on R/W03 at Glenswinton,which is 380 m long and has a compacted gravel surface. When the brakes were applied, the a/c drifted to the left of the centreline and, towards the end of the runway at lowspeed, it struck a tree. The a/c's braking performance was probably degraded due to the poor condition of the RH brake unit and the compacted gravel runway surface may have been a less effective surface for braking than a conventional paved surface. AAIB Bulletin 07/2011, ref: EW/G2011/04/15.

CAA Closure: The a/c was flown by a pilot with a flying instructor for dual flying experience. The pilot took off from Shobdon, flew to the Clee Hill area and then returned to perform touch-and-go practice. The grass strip adjacentto R/W 09 was being used for this exercise. The wind was reported to be five to seven knots from the north with benign weather conditions. At a height of approximately 20ft after the second touch-and-go, the a/c veered to the right. The pilot started correcting when the instructor took control. The a/c was flown across the asphalt runway to the right and landed on the adjacent grass. The landing gear collapsed on landing, damaging the engine cowling and frontstrut but no injuries were sustained. It was reported that a modification had recently been approved to address undercarriage collapse issues but it had not been embodied onthis a/c. AAIB Bulletin 08/2011, Ref: EW/G2011/04/23.
CAA Closure: After an uneventful take-off, at approximately 500ft agl, the engine began to run roughly and lost power. There was sufficient altitude available for the pilot to return to the airfield where he carried out a landing on the reciprocal runway. An inspection of the engine revealed damage to the bottom of the spark plugs fitted in the rear cylinder. After replacing all of the spark plugs the engine ran smoothly and the pilot, believing the fault hadbeen corrected, prepared to take-off again. No problems were observed during the second take-off, but at a height of 90ft above the runway, the engine began to run roughly once again. With insufficient height to land in the next field, the pilot attempted to land on the remaining length of the runway. The a/c landed hard and came to a halt resting on its LH wingtip. The pilot was uninjured. A detailed examination of the engine revealed damage to the crown andunderside of the rear piston. The evidence suggested thatthis had been caused by foreign object debris, passing from the crankcase, through the rear cylinder inlet valve, into the cylinder. No defects were observed within the crankcase and no further foreign objects were found. It could not be determined when the foreign
CAA Closure: After take-off on a Permit to Fly renewal flight, the engine stopped. The subsequent forced landing ina corn field adjacent to the airfield caused the LH main landing gear to collapse. AAIB Bulletin 09/2011, Ref: EW/G2011/06/02.
CAA Closure: The pilot selected the landing gear up aftertake-off and then noticed that the circuit breaker for the gear had tripped, preventing the gear from retracting. He attempted to raise the gear using the hand operated system but was unable to obtain a green light for the main gear. He returned to the departure airstrip and during the subsequent landing the a/c veered to the left as it slowed down. The pilot exited the a/c and was uninjured. The damage caused to the main gear during the landing made it difficult to determine why it had failed to retract fully. However, the tripping of the circuit breaker may have been indicative of a mechanical failure or jamming of the gear mechanism. AAIB Bulletin 11/2011, Ref: EW/G2011/05/18

CAA Closure: The cause of the event is probable that initial oscillation on the landing rollout was due to a failure of the floor cross-member at one or both of the support frame rear attachment points caused by a long term stress or fatigue fractures, allowing the nose leg to move freely sideways and create an uncommanded and arbitrary steering input. DGAC & SB 91 refers, but does not call for a periodic inspection.
Severe a/c damage. A/c possibly written off. CAA Closure: During the take-off run the a/c began deviating to the left, towards a parked flex-wing a/c, despite the pilot applying full right rudder and stick. On realising that he would not be able to avoid the parked a/c, he deliberately lifted into the air with insufficient airspeed. Having missed the flex-wing he then tried to turn his a/c to become parallel with the runway. During this manoeuvre, carried out with insufficient airspeed, the left wing dropped causing the a/c to turn to the left again and head towards a mower with two people beside it. The pilot then attempted to turn sharply to the right with some success, but the left wing dropped and struck the ground, levelling the a/c and altering its direction of travel again. The a/c crossed the runway and a taxiway before colliding with a sea wall. The pilot believed that the a/c's initial deviation to the left was caused by the left wheel brake binding. AAIB Bulletin 10/2011, Ref: EW/G2011/06/16.
CAA Closure: Shortly after lifting off the runway, the engine lost power such that the a/c was unable to gain height. The pilot turned the a/c to the left in order to avoid obstacles ahead but, as the engine continued to lose power, the a/c lost altitude and eventually stalled into marshyground from a height of around 6ft. No definitive explanation for the engine power loss was found, although accumulations of miscellaneous debris in the fuel system may haverestricted the fuel flow at take-off power. AAIB Bulletin12/2011, Ref: EW/G2011/07/03
CAA Closure: Following normal pre-flight checks, the pilot took off and climbed to a height of between 100 and 150ft agl, at which point the engine lost power and he could no longer maintain altitude. Due to the close proximity of power lines, the choice of location for a forced landing was limited to a field containing crops, which were approximately 1.8m high. The pilot elected to stall the a/c as ittouched the top of the crop, resulting in damage to the nosewheel and pod assembly of the a/c when it subsequently contacted the ground. Investigation of the engine identified a failure of the rocker arm that operated the inlet ports on one cylinder. As the engine was a twin cylinder model, the power generated by one operational cylinder alone had not been sufficient to maintain flight. AAIB Bulletin 10/2011, Ref: EW/G2011/06/24

CAA Closure: The pilot reported that, shortly after take-off, the a/c did not climb as expected and, with the a/c in level flight and throttle fully open, failed to accelerate as expected. The pilot subsequently made a forced landing onto a road and the rotor impacted the ground. AAIB Bulletin 09/2011, Ref: EW/G2011/07/05.
A/c was on a flight test following a double engine change. When landing gear was selected up it started to move, gear lights extinguished but red light stayed on and gear handle remained up. From the ground both main legs were seento remain dangling half up. Flight reference cards checked and after two minutes gear handle was selected down but nothing happened, so gear was selected up and again nothing happened. Gear was selected down again and hydraulic hand pump was used - all legs returned to down position with three green lights illuminated and a/c landed normally. Unidentified thump heard from LH side of a/c during recoverybut no damage apparent on post flight inspection. Subsequent investigation revealed that LH engine hydraulic pump had seized and pump drive had sheared. Two new pumps had previously been installed during double engine change with ground testing satisfactory. LH pump replaced and all hydraulic system components checked and found satisfactory. Subsequent ground testing and air test satisfactorily completed. Seized pump returned to manufacturer for inspection and report. Suspected that when pumps were originally installed there may have been air in system that meant gear was not driven up and may have
CAA Closure: The pilot took off from RAF Honington to practise circuits. He had completed his downwind checks, which included selecting the carburettor heat to hot. After turning onto the base leg and throttling back, the engine cut out. He checked the fuel selector and the magnetos, which were both on. As the engine did not have an electric starter and given the height and distance to the runway threshold, the pilot had no option other than to make a forced landing. He selected a field short of the runway and then made a MAYDAY call. The a/c touched down, main wheels first, approximately a third of the way down the large ungrassed field. Soon after the nosewheel touched down the a/c flipped over, coming to rest inverted and trapping the pilot. Passers-by helped to right the a/c so that the pilot could free himself. The Suffolk Police Air Support helicopter, the local and RAF Honington fire services and an ambulance also attended the scene. The pilot was uninjured. No obvious explanation could be found for the engine failure. The pilot considered that his frequent practising of forcedlandings and ensuring that the straps on his harness weretight prior to touchdown contributed to the safe outcome of this accident. AAIB Bulletin 10/2011, Ref: EW/G2011/08/04

CAA Closure: During approach the pilot observed that the three landing gear green 'Down and Locked' lights were illuminated. On touchdown the LH main landing gear collapsed and the 'In Transit' light illuminated. Subsequent investigation revealed that wear on the LH main landing gear actuator piston prevented the complete engagement of the downlock hook on the lock-pin. However, the partial engagement had actuated the limit switch that illuminated the 'Down and Locked' light. AAIB Bulletin 11/2011, Ref: EW/G2011/08/05
Damage to RH main landing gear, RH wing and propeller. CAA Closure: Following a normal landing, the RH landing gear collapsed during the ground roll as a result of a failure of the RH landing gear cross-strut. AAIB Bulletin 12/2011, Ref: EW/G2011/08/13
CAA Closure: Shortly after becoming airborne the engine stopped. In the pilot's attempt to avoid a road and overhead electrical cables, the a/c landed heavily and was extensively damaged. The pilot was uninjured. AAIB Bulletin 11/2011, Ref: EW/G2011/09/08.
Landing gear doors and retraction mechanism damaged.
Landing gear, engine, propeller and fuselage damaged. CAA Closure: Following a normal landing, during which the a/c touched down on the mainwheels, the landing gear collapsed during the ground roll, shortly after the nosewheel had been lowered onto the runway. The landing gear position microswitches only give the relevant position of the screw jack and do not detect if the brace struts have moved into the over-centre position. The pilot reported that he had a 'green' gear indicating light and the nose landing gear retracted during the ground roll shortly after the nosewheel made contact with the runway. This suggests that the nosewheel brace strut might not have been fully over-centred and, consequently, the nose landing gear would have started to collapse rearwards as the wheel was lowered onto the runway. As it collapsed, a force would have been transmitted through the control linkages sufficient to detach the forward part of the winding handle securing bracket away from the pedestal. At the same time, the main landing gear torquetube would have rotated, causing the main landing gear brace strut to move out of the over-centre position and thereby allowing the main landing gear to
CAA Closure: Following an uneventful approach into KembleAirfield, the aircraft's nose gear collapsed on touchdowndespite all three green 'down-and-locked' lights being illuminated in the cockpit. The aircraft suffered damage to the underside of the nose and to both propellers, but bothoccupants were uninjured and they exited the aircraft normally. Subsequent engineering analysis revealed a corrodeddownlock microswitch on the nose gear actuator. AAIB Bulletin 6/2010, Ref: EW/G2010/01/04.

CAA Closure: Shortly after touching down from a post-restoration check flight, the landing gear retracted and the aircraft came to rest on its lower fuselage. The incident was attributed to insufficient tension in the landing gear lever trigger spring which allowed the lever to move out of the 'Down' position, causing the landing gear to retract. AAIB Bulletin 04/2010, ref: EW/G2010/01/07.
CAA Closure: The aircraft was returning to Northrepps Airfield after a local flight in fine weather. The wind was light from the west and the aircraft touched down after an uneventful approach to R/W22. After touchdown, the aircraft began veering to the left and continued to do so despiteattempts by the pilot to correct. It departed the left edge of the runway and entered a soft, muddy ploughed field at low speed at which point the nosewheel dug in and the aircraft gently tipped over, ending up inverted. Both pilotand passenger were wearing full harnesses and escaped injury. Subsequent inspection of the landing gear revealed a damaged and deflated LH mainwheel tyre. Inspection of the grass runway showed a single gouge created by the left wheel and wheel spat, tracking from the runway centreline to where the aircraft left the runway. The pilot considered that the left mainwheel tyre had deflated at some point prior to touchdown and this had caused the aircraft to departthe left side of the runway. AAIB Bulletin 06/2010, Ref: EW/G2010/03/02.
CAA Closure: During the landing roll-out the nosewheel started to shimmy and then detached from the nose gear. The aircraft came to a halt on its nose gear leg. The nosewheel axle was subsequently found to have failed close to where it meets the nose leg. The causes of the shimmy and axlefailure were not established. There were no injuries. AAIB Bulletin 06/2010, Ref: EW/G2010/03/07.
CAA Closure: During the landing roll the RH main wheel assembly detached from its axle. Examination revealed that the four fasteners securing the RH axle to the landing gearhad failed as a result of the nuts having been pulled from the four attachment bolts. The investigation could not determine the cause of the failure. It was noted that the threads on the attachment bolts can be damaged when the axles are removed from the landing gear. One Safety Recommendation, nr 2010-046, was made to the a/c manufacturer recommending that new nuts and bolts should be used when the axles are replaced or refitted to the landing gear. AAIB Bulletin 10/2010, Ref: EW/C2010/04/06.
CAA Closure: Whilst landing on a dry grass runway the pilot lost control as the nosewheel was lowered to the surface. The microlight tumbled, causing minor injuries to both occupants. Based upon a subsequent inspection of the aircraft, the pilot thought that the nosewheel tyre may have been under-inflated prior to landing. AAIB Bulletin 06/2010,Ref: EW/G2010/04/12.

Both pilots were required to maintain level flight. CAA Closure: The serious incident was caused by the failure of the Automatic Loading System (ALS) (SAZ) failing. Interstate Aviation Committee of Russia Final report.
CAA Closure: Whilst practising circuits, the a/c experienced a reduction in engine power leading to a wheels-up forced landing in a field with minimal damage. AAIB Bulletin 10/2010, Ref: EW/G2010/04/23.
CAA Closure: The a/c suffered a power loss of unknown cause whilst in the cruise. The subsequent forced landing resulted in significant damage to the a/c. AAIB Bulletin 09/2010, Ref: EW/G2010/05/05.
CAA Closure: Whilst landing, the RH main landing gear legfailed and detached from the a/c, causing the underside of the fuselage and the RH wingtip to contact the runway. The a/c veered to the right and came to rest beside the runway, facing in the opposite direction. Both occupants wereuninjured and able to vacate the a/c unaided. The pilot reported that the weather conditions were good, with a surface wind from 060deg at 5kts and that the approach and touchdown were normal. He had satisfactorily completed a proficiency check with an instructor immediately prior to thisflight. The detached section of the steel landing gear leg was returned to the AAIB for examination. Inspection of the fracture surfaces revealed evidence of an approximately 15mm deep pre-existing crack propagating from the rear edge of the gear leg. The crack surfaces in this region were heavily corroded, indicating that the crack had been present for some time prior to the failure. AAIB Bulletin 09/2010, Ref: EW/G2010/05/20.
CAA Closure: Despite cycling the landing gear several times, the RH main gear remained in the retracted position resulting in the pilot landing the a/c on the nose and LH main landing gear. The pilot and passenger were uninjured but the a/c was extensively damaged. The investigation established that the RH landing gear jammed in the wheel well as a result of the failure of a trunnion which connected the landing gear damper to the wheel trailing arm. The failure was caused by stress corrosion cracking. Three safety recommendations, nrs 2010-066, 2010-067 and 2010-068, were made to the a/c manufacturer. AAIB Bulletin 11/2010. Ref: EW/G2010/06/03.

CAA Closure: The a/c was being flown at an altitude of 3500ft in VMC when the pilot noted a marked drop in performance of the LH engine. Despite checking engine control positions and selecting an alternative fuel tank, he could notrestore power. He decided to keep the engine running as it appeared to be producing some power and the oil pressurewas normal. A PAN was declared to Solent Radar who gave permission for a straight-in approach to Southampton Airport. As the flight continued the pilot found it increasinglydifficult to maintain height and he decided to land at anairstrip near Lymington as he thought he would be unable to reach Southampton. To avoid creating extra drag, he didnot extend the landing gear or flaps until on final approach. The landing gear had not locked down by the time the a/c landed and it collapsed on touchdown causing the a/c to stop quickly. The pilot and passenger were able to vacate the a/c unaided and once clear they advised Solent Radarof the outcome via the emergency services. AAIB Bulletin 10/2010, Ref: EW/G2010/06/17.
CAA Closure: The pilot reported that he felt the RH main gear start to collapse on touchdown. He selected the gear 'Up' and attempted a go-around, but the a/c touched the ground so the pilot chose to land with the gear retracting. AAIB Bulletin 10/2010, Ref: EW/G2010/06/20.
CAA Closure: The pilot reported that the purpose of the flight was to update his currency. The cloud was overcast at about 1500ft, so he elected to fly circuits at the airfield. Grass R/W02 was in use, the wind was light from the north-east and the visibility was good. The first circuit was described as normal, as was the second, until the a/c bounced on touchdown. The subsequent landing was flat and firm and, after rolling a few metres, the nose landing gearcollapsed. The propeller blades struck the surface and the a/c came to a halt on the runway with the engine stopped. The pilot turned off the fuel, the magnetos and the master switch and vacated the a/c normally, uninjured. There was no fire. In an open and honest report the experienced pilot considered that the accident occurred because, havingbounced, he did not go-around or, alternatively, maintainthe correct landing attitude. Thus, during the subsequentfirm landing the nose landing gear was overloaded and collapsed. He also considered that his lack of recent experience in light a/c may have been a factor. AAIB Bulletin 09/2010, Ref: EW/G2010/06/15.
CAA Closure: During final approach, the pilot increased the throttle but the engine did not respond. The a/c had insufficient airspeed and altitude to reach the airfield andcrashed into a hedge short of the runway. AAIB Bulletin 10/2010, Ref: EW/G2010/06/23.

CAA Closure: Following a touch-and-go, the a/c suffered asudden power loss whilst climbing through 400ft agl. The pilot executed a forced landing in a field, during which the a/c's wings, engine mount, nose landing gear and propeller were damaged. Subsequent engineering examination of the a/c did not positively identify the reason for the engine failure although an electrical fault was identified in the LH magneto primary lead that was sufficient to prevent the LH magneto from functioning. AAIB Bulletin 10/2010, Ref: EW/G2010/06/16.
On landing, the a/c bounced back into the air, the nose then pitched down and the a/c landed on the nose wheel. Thenose wheel detached, the fractured nose leg scraped alongthe runway and the a/c slewed to the left of the runway. AAIU Report 2010-020, ref: IRL00910047.
CAA Closure: The a/c suffered an engine failure followingpower reduction whilst on the downwind leg of a circuit. The pilot carried out a forced landing in a crop field, during which the a/c sustained damage. The prevailing meteorological conditions at the time of the accident were favourable for the formation of serious carburettor icing at descent power settings. Lack of application of carburettor heat and subsequent carburettor icing were the most likely causes of the engine failure. The pilot was uninjured. AAIB Bulletin 11/2010. Ref: EW/G2010/06/21.
This occurrence is subject to investigation by the FrenchAuthority (BEA). On receipt of their report, the CAA's records will be updated accordingly and the occurrence may be opened if further action is deemed necessary.
CAA Closure: The pilot reported that, following a glide approach, the microlight landed normally. However, on touchdown the front forks of the nose landing gear collapsed, allowing the nosewheel to fold rearwards. The a/c continuedto slide along the runway for approximately 20 metres before coming to rest; the pilot then announced to Perth Radio that the a/c was unable to clear the runway. He turned off the electrical master switch and climbed out of the a/c. The reported wind was 090/12kts. Both the pilot, and an instructor/co-owner who observed the landing, considered the touchdown normal. The owners have undertaken to send the front forks to the a/c manufacturer, to examine the fracture for evidence of pre-existing damage. AAIB Bulletin 02/2011, Ref: EW/G2010/06/35.
Aircraft had electrical over-volt warning shortly after take-off and had returned when total electrical failure occurred and landing gear was unable to be lowered either on normal system or emergency system. This occurrence is subject to investigation by the French Authority (BEA). On receipt of their report, the CAA's records will be updated accordingly and the occurrence may be opened if further action is deemed necessary.

CAA Closure: The pilot had rigged the a/c prior to being inspected and test flown by a Light A/c Association (LAA) inspector. Whilst awaiting his arrival the pilot decided to conduct a 'practice take-off' - essentially an accelerate-stop manoeuvre on the runway. However, at about 50kts the a/c started to drift to the right and the pilot was unable to prevent the a/c from departing the runway and striking an earth bank. It was subsequently found that a safety pin, which retained a pin attaching the right-hand flap toits operating linkage, was missing. However, it could notbe determined whether this was a factor in the accident. AAIB Bulletin 12/2010 Ref: EW/G2010/07/15.
CAA Closure: It is likely, given the fact that the side stick commands generate a rate of roll command and that theailerons deflected in the correct sense, this apparent lack of response was due to the prevailing atmospheric conditions.
CAA Closure: The nose landing gear could not be raised after take-off and could not be locked down. A successful wheels-up landing was performed. A broken universal joint inthe nose gear actuating mechanism was found to be the cause. AAIB Bulletin 12/2010, Ref: EW/G2010/07/18.
CAA Closure: The a/c had been flown earlier that morning to take part in the 'Fly-UK 2010' round-Britain event. Thepilot completed the pre-flight checks and the a/c then took off. At around 800ft agl the engine started to lose power and a few seconds later, stopped. The pilot had a limited choice of options for a forced landing and chose a narrow strip of long grass alongside a fence. During the approach the pilot allowed the airspeed to decay excessively and the a/c stalled at a height of between 6 and 10 ft. It then struck the ground, damaging the landing gear and both wings; the pilot was uninjured. The fuel pipe in the wing tank had recently been replaced and the pilot considered that a fuel problem associated with this pipe might have been a contributory factor. AAIB Bulletin 11/2010, Ref: EW/G2010/06/38.
CAA Closure: On 2 August 2010 the a/c ground looped during a landing at a farm strip. This had occurred previously,on 22 June 2010, to a co-owner. The pilot in the August event reported that only light lateral force was required for the tailwheel to castor freely, with weak centring springs making directional control difficult. With the mechanical problem rectified, the pilot reported the ground handling much improved. The accidents were not reported to the AAIB at the time as the two pilots did not appreciate thatthis is a statutory requirement. AAIB Bulletin 12/2011, ref: EW/G2010/08/21. See also 201014547.

CAA Closure: The pilot had been flying circuits for approximately 30mins with no abnormal indications. Then, following rotation and climb out to 200ft agl, the engine stopped abruptly with the rpm dropping to zero. The pilot landedin a field but touched down fast at around 50mph. The nosewheel dug into the ground and the a/c rolled over, causing extensive damage to the airframe but no injuries. AAIB Bulletin 02/2011, Ref: EW/G2010/09/02.
CAA Closure: Following an uneventful flight, the a/c touched down and veered to the left; the pilot was unable to correct this as it was apparent that the rudder had jammed.The a/c departed the runway and flipped over onto its back. Both occupants were uninjured. The rudder jam was subsequently confirmed and was similar to other incidents involving Jabiru a/c. AAIB Bulletin 04/2011, Ref: EW/G2010/09/23.
CAA Closure: The a/c suffered a power loss shortly after take-off. It was extensively damaged during the subsequentforced landing when it struck the upslope of a deep hollow that was not visible from the air. The power loss was thought to have been caused by an ignition system failure. AAIB Bulletin 03/2011, Ref: EW/G2010/10/05.
CAA Closure: During the flight, in light winds and with good visibility, the pilot noticed a higher than normal cylinder head temperature reading. He decided to make a precautionary landing on the beach at Oldshoremore, Kinlochbervie. The landing was on firm sand but at the end of the landing run the nosewheel sank into softer sand, dug in and the plane rolled over, coming to a stop upside down. The a/c sustained wing, propeller and cockpit damage but there were no injuries to the pilot or passenger. The pilot contacted the police and pulled the a/c up the beach for recovery the next day. In hindsight the pilot stated that his precautionary landing, in response to the higher cylinder head temperature, may have been unnecessary. At the time of writing this report, the cause of the higher than normal cylinder head temperature was unknown. AAIB Bulletin 01/2011, Ref: EW/G2010/10/12.

CAA Closure: A prospective purchaser had arranged for a pilot with previous experience on similar types to fly the tail wheeled a/c and assess it for him. The weather conditions were "clear and bright" with light north-north westerly winds estimated at 3 or 4kts. The owner briefed the pilot about the a/c, emphasising that as the propeller was relatively coarse, the pilot should lift the tail promptly before accelerating to lift-off speed. There was some difficulty starting the engine, but once it was started the pilot taxied to the grass runway and began a take-off. Witnesses stated that the grass was damp and that the tail wheeldid not lift. The pilot perceived that the a/c would not become airborne and aborted the take-off attempt. The a/c came to rest in a hedge, sustaining damage. The pilot evacuated the a/c without difficulty. Those involved subsequently commented that the accident may have arisen from the take-off technique used, the length of the grass or the engine not producing sufficient power. AAIB Bulletin 01/2011,Ref: EW/G2010/10/13.
CAA Closure: Following pre-flight inspection, during which water was found and drained from the fuel tanks, and a number of aborted starts due to battery problems, satisfactory engine runs were performed. Shortly after take-off, atabout 600ft agl the engine lost power. During the subsequent forced landing the a/c hit a concealed dry stone wall but both occupants escaped injury. The conditions at the time were close to those during which serious carburettor icing at any power could have occurred. AAIB Bulletin 02/2011, Ref: EW/G2010/11/03.
The a/c was positioning to Doncaster Airport for minor maintenance. Shortly after a normal touchdown, the RH main landing gear trailing link failed and both main wheels on that side detached. The a/c slid to a halt just off the RH side of the paved surface. The link failed due to a long stress corrosion crack. One Safety Recommendation, nr 2011-072 addressed to the a/c manufacturer, is made for frequent visual inspection of the links for the presence of such cracks. Part of this investigation utilised Flight DataRecorder download. Whilst the accident flight was a private flight, the a/c is normally operated under an Air Operators Certificate under EU-OPS requirements. EU OPS 1.160 (a) (4) (ii), requires the operator to keep a document thatdefines how the FDR contents is converted into engineering units. The operator did not hold such a document. The FDR installation was part of the Type Certification (TC) of the a/c. Enquiries with the a/c manufacturer ultimately yielded two documents, neither controlled, that between themenabled adequate analysis of the FDR data to be performedfor this event. No controlled document was available fromany source to enable the accurate decode of the FDR, despite the a/c, with FDR installation, having an EASA TC. Other
CAA Closure: Whilst practising solo circuits, a student pilot experienced a loss in engine power. He attempted a forced landing, but the a/c touched down at the far end of the field and collided with a boundary hedge before coming to rest on a road. AAIB Bulletin 04/2011, Ref: EW/G2010/12/01.

CAA Closure: The pilot planned to fly an ILS approach with the autopilot engaged. The a/c was given radar vectors to intercept the final approach course. The pilot reported that he was flying with the autopilot engaged and maintaining the assigned heading. He noticed that he had inadvertently descended below the assigned altitude of 2,000 ft, to1,800 ft. He disengaged the autopilot, in order to correct the height manually, but, while he was doing so, went through the localiser. He reported to ATC that he would re-establish on the approach. He then attempted to re-engage the autopilot and continue the approach but this was unsuccessful. The pilot again reverted to manual flight but became disorientated and the a/ct went through a series of erratic manoeuvres. The pilot followed the controller's instructions and subsequently accepted a second radar vectored ILS approach, which was flown successfully. AAIB Bulletin 07/2011, Ref: EW/G2010/12/08.

CAA Closure: Whilst joining the circuit to land, the pilot selected the fuel selector from the belly tank to the main tank for landing as required by normal procedures. The engine immediately faltered and appeared to cut out; reselecting the belly tank had no effect. He declared an emergency and was immediately cleared to land. The a/c landed heavily and the landing gear collapsed but both occupants were uninjured and able to vacate the a/c normally. The pilot reported that the fuel tanks still contained approximately seven gallons of fuel and that he suspects an airlock may have developed during the change in tank selection. He also commented that after the engine failure, the rate of descent appeared to increase markedly when the propeller stopped rotating. AAIB Bulletin 02/2011, Ref: EW/G2010/09/18.

AAIB Bulletin 5/2006, ref: EW/G2006/01/21 - Summary: During the first flight following maintenance work the pilot was unable to confirm the full extension of the nose landing gear. The nose gear collapsed during landing. It was notpossible to conclusively determine the reason for the failure of the nose landing gear to fully extend.
CAA Closure: No CAA action appropriate.

AAIB Bulletin 9/2006, ref: EW/G2006/06/03 - Summary: Following a normal approach for a 'touch and go' landing on a grass runway, the aircraft touched down smoothly on its main wheels which was followed by gently lowering the nose wheel. Engine power was applied and the flaps selected to their take off position when a bang was heard and the aircraft stopped violently and came to rest in a nose down position. Examination revealed that the nose landing gear leg had failed in overload following severe plastic deformation consistent with a high upward vertical load being applied to the nose wheel. It was not possible to determine the number of flights between when the deformation occurred and the final failure. See also 200705336 and 200204026.
CAA Closure: No CAA action appropriate.

CAA Closure: Following a normal landing the right main gear leg separated from its wing spar attachment. Two of the bolts which had secured the leg were found to have failed due to fatigue. The root cause of the fatigue failure could not be established. AAIB Bulletin 10/2012, Ref: EW/C2012/03/06.
CAA Closure: The gyroplane suffered a partial loss of engine power during take-off. The instructor landed the a/c on the remaining runway but was unable to bring it to a stop before it ran off the end. When the engine was examined,the spark plugs for cylinder 4 were found to be 'wet' with fuel, indicating that they had not been firing. The engine was subsequently run successfully. During discussion between the pilot and engineering personnel, the increased engine operating temperature, the relatively warm day and the use of winter grade MOGAS were considered to have been conducive to vapour lock in the fuel lines, although this would not have accounted for the 'wet' spark plugs in cylinder 4. AAIB Bulletin 06/2012, Ref: EW/G2012/03/19.
CAA Closure: The pilot started the engine and allowed it to warm up before taxiing to the end of the runway. He then completed the pre take-off checks, before taking off normally. As the a/c climbed away the engine started to run roughly and vibrate, and the engine speed dropped. The pilot lowered the nose to maintain airspeed. He flared as the a/c neared the ground but the left wing dropped and the a/c struck a hedge. The pilot and passenger exited without injury. The cause of the engine problem was not established, although carburettor icing was considered a possible cause by the pilot. AAIB Bulletin 08/2012, Ref: EW/G2012/04/07.
CAA Closure: The a/c's cockpit canopy became unlatched during climb-out after take-off. The resulting high drag of the partially-open canopy meant the pilot had to perform a forced landing on a disused runway. The landing was heavy and a fire developed in the engine compartment which destroyed the a/c. In the pilots assessment of the cause of the accident, the pilot says he believes that the sudden encounter with turbulence caused the canopy to unlock and reiterates that he was surprised at the degradation in performance caused by the partially-open canopy. The unanticipated high drag of a partially-open canopy was also a major factor in the forced-landing and overturning of an Aero AT-3 R100. AAIB Bulletin 10/2012, Ref: EW/G2012/05/21.
CAA Closure: The a/c had flown after being repainted. During the approach, the nose landing gear failed to extend. The a/c landed with the nose landing gear retracted, damaging the forward lower fuselage and nose landing gear doors. Tests and inspections were unable to identify a probable cause for the failure of the nose landing gear to extend. AAIB Bulletin 10/2012, Ref: EW/G2012/04/12.

CAA Closure: An ASW19B glider was on approach to R/W27S while a Mainair Blade flex-wing microlight was on approach to the intersecting R/W05. Both pilots made downwind calls but due to a radio problem in the microlight neither pilot heard the other's calls. When the duty instructor (also A/G operator) became aware of the conflict he radioed the microlight to abort, but this call was not received by the microlight pilot. The glider pilot heard the call but was already committed to landing and did not know from which direction the microlight was approaching - he touched down and looked ahead but did not see any other a/c. The microlight appeared suddenly on his left, at about the 10 o'clock position, and he instinctively applied full left rudder to avoid it but the glider's right wing struck the microlight, seriously injuring its pilot. If the radio on the Mainair Blade had been operating correctly the pilot would have heard the duty instructor's calls to abort and the accident could have been avoided. Had the radio been working, both pilots would also have been aware of the other's location in the circuit before the conflict was set up. Since the pilot of Mainair Blade was using a runway that was rarely used and was not designated by the club, it would have been necessary to be extra vigilant
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CAA Closure: Whilst landing, the pilot heard a whining sound followed by severe vibration and a swing to the left. He was unable to prevent the a/c from leaving the paved surface, in the course of which the nose landing gear collapsed. The nosewheel tyre was found to have deflated and theNLG leg had folded into the retracted position due to overload failure of the downlock mechanism. The nosewheel tyre had completely deflated due to what appeared to be massive wear of the sidewall on the right side. The inner tube had been liberated from the inside and was wrapped around the axle. There was no immediately apparent reason for thefailure of the bracing tube. Circumstantially, it is mostlikely that it was damaged either during taxiing or ground handling, since the attachments were intact. AAIB Bulletin 08/2012, Ref: EW/G2012/05/08.

CAA Closure: Technical inspections determined crack in fuel line between fuel tank and upper drainage valve as likely cause of loss of fuel. A clear cause of this crack could not be determined.
CAA Closure: The a/c experienced a loss of power immediately after take-off and a forced landing was attempted. The a/c probably stalled from a low height and struck the ground, causing extensive damage to the a/c but without serious injury to either occupant. The pilot had no precise recollection of the sequence of events between heading towards the field and finding himself upside down in what remained of the cockpit, although he suspects that the a/c stalled and dropped a wing which is borne out by study of photographs of the ground marks and the wreckage. The reason for the engine losing power is also not known, although there were no obvious anomalies visible externally. AAIB Bulletin 10/2012, Ref: EW/G2012/06/02.
CAA Closure: Pilot flew a curved approach from the downwind position and touched down on the mainwheels. As he gently lowered the nose landing gear onto the runway it collapsed, causing the propeller to strike the runway and shatter. The a/c slid for a short distance but remained on the runway. The pilot made the a/c safe and vacated it with his passenger; there were no injuries. The weather conditions were reported as good, with the surface wind from 330deg at 15kts. AAIB Bulletin 11/2012, Ref: EW/G2012/06/04.
CAA Closure: Towards the end of an otherwise uneventful landing at a farm strip in calm conditions the left main tyre suffered a puncture. At approx 20kts the pilot felt the a/c swing to the left, accompanied by a high level of vibration. He was unable to counter the swing and the a/c entered a field of standing crops to the side of the strip, coming to an abrupt stop. Neither the pilot nor his passenger suffered injury. AAIB Bulletin 10/2012, Ref: EW/G2012/07/08.
CAA Closure: At about 200ft aal after take-off the engine suffered a sudden loss of power and the pilot initiated a forced landing. The aircraft touched down in a field at the end of the runway but then it hit a fence, a hedge and a large mound, which caused significant damage to the aircraft. The loss of power was caused by failure of a clamp between the turbocharger compressor outlet and the turbo pipe assembly. This clamp had failed due to a fatigue crack that had initiated at multiple sites on the inner diameter and then propagated through the thickness of the sidewall. Following the accident the maintenance organisation discovered another cracked clamp, which had not yet failed, on another aircraft fitted with the same engine type. Three Safety Recommendations, nr 2013-018, 2013-019 and 2013-020, all addressed to the engine manufacturer. AAIB Bulletin 10/2013, Ref: EW/C2012/07/06.

CAA Closure: When the a/c returned to its departure airfield because of an engine oil leak, the nose landing gear leg would not lock down. The pilot performed a successful gear-up landing on the grass. Upon examination, it was found that a fractured hydraulic pipe was responsible for the failure of the leg to lock down. AAIB Bulletin 01/2013, Ref: EW/G2012/07/02.
CAA Closure: The a/c suffered a loss of engine power, believed to be due to fuel starvation. A forced landing attempt was made to a disused runway, but the engine stopped before reaching it. The a/c touched down in a wheat field and inverted. Both occupants were uninjured but had extreme difficulty escaping from the wreckage. AAIB Bulletin 10/2012, Ref: EW/G2012/07/14.
CAA Closure: After take-off on a training flight, the a/c's engine lost power. The commander took control and elected to make a 90deg turn to the right, towards a crop field, in order to avoid a hedge and power lines. During the landing the a/c's right wing touched the crop, resulting in a ground loop that damaged the wings, nose fairing and fuselage main tube. The a/c owner reported that following the accident the engine was stripped, revealing scoring marks on the exhaust side of both pistons, consistent with engine overheating and seizure. He attributed the engine failure to misadjusted carburettor jet needles in both carburettors, which caused the engine to run with a lean mixture and subsequently overheat. AAIB Bulletin 11/2012, Ref: EW/G2012/07/17.
CAA Closure: The pilot was unable to lower the main landing gear and, despite attempts by the pilot and passenger to lower the gear, the a/c landed with the nose gear extended and the main landing gear still retracted. It is likely that the cause was either an in-flight loss of hydraulic fluid or an internal failure in the hydraulic pump. AAIB Bulletin 11/2012, Ref: EW/G2012/07/19.
CAA Closure: After take-off, the pilot observed that the right main landing gear indication light was illuminated, which indicated that the landing gear had failed to retract fully. After cycling the landing gear several times, including the use of the manual extension/retraction system, the light remained illuminated. As a precaution, the pilot completed the remainder of the flight with the landing gear in the 'DOWN' position. On landing after a normal touch down, the right main landing gear collapsed, followed by the left main and nose landing gear. The pilot was uninjured. The pilot attributed the accident to a failure of the landing gear locking mechanism which may have been damaged following a heavy landing which had occurred a few weeks earlier. AAIB Bulletin 01/2013, Ref: EW/G2012/07/33.

CAA Closure: The gyroplane suffered a loss of engine power soon after lift-off. The pilot arrested the gyroplane's forward speed and made a hard landing at the runway end. The pilot's investigation showed that no electronic fault codes had been registered and that the fuel pumps operated normally and produced the correct pressure. Although the engine idled at the specified rpm in ground runs after the accident, it subsequently idled significantly higher, and the recently fitted throttle position sensor was found to have failed. It was not possible to establish if this was as a result of the accident. The temperature of the day was such that the possibility of fuel vapour lock could not be excluded. AAIB Bulletin 10/2012, Ref: EW/G2012/08/10.
CAA Closure: On the seventh landing of the day the pilot reported hearing a 'crack' sound just after touchdown. Suspecting a failure in the landing gear, the pilot shut down the engine whilst taxiing. The a/c came to a controlled stop with the right wing low, but not touching the ground. The damage was inspected by the repair agency for the a/c. Inspection revealed that the hydraulic damping unit, to which the undercarriage retaining bungees are attached, had sheared at its upper end, causing the landing gear partially to collapse on the right side. The repair agency consider that the bungees that hold the landing gear in place prevented total collapse of the landing gear, and damage to the wing and propeller, and comment that inspection of this strut is part of the a/c periodic 50-hour check. The repair agency suggests that pilots who fly this a/c regularly inspect the top of the strut for signs of wear. The pilot assessed the cause of the failure to be 'wear and tear'. AAIB Bulletin 02/2013, Ref: EW/G2012/08/15.
CAA Closure: The pilot was performing a solo flight in fine weather to build hours. With the fuel gauge reading one-quarter full, he decided to return towards the airfield after practising some turns to the left and right. During the return to the airfield, the engine stopped. After selecting the largest field (which contained a standing crop of potatoes) and turning into wind, the pilot executed a landing as 'a normal landing on a runway'. At touchdown, the a/c stopped abruptly but the pilot, who was wearing a full harness, was uninjured. The pilot considered that with a low fuel quantity, air could have been introduced into the fuel system during the left and right turns which caused the engine to stop. AAIB Bulletin 01/2013, Ref: EW/G2012/08/17.
CAA Closure: The a/c's climb rate was lower than expectedafter take-off and it was subsequently unable to maintainaltitude. The pilot made a forced landing into a field. The cause of the apparent power loss was not determined. AAIB Bulletin 02/2012, Ref: EW/C2012/05/03.

CAA Closure: Following take-off from grass R/W24 at Sherburn in Elmet Airfield, the landing gear failed to retract fully. The pilot was unable to lower the landing gear either by normal means or by using the emergency extension system. The pilot carried out a wheels up landing in a crop field adjacent to R/W21 at Gamston Airport. The propeller and lower fuselage skin were damaged during the landing, but the pilot and passenger were uninjured and vacated the a/c without assistance. It was determined that deflation ofthe RH landing gear oleo had prevented full retraction ofthe landing gear. During subsequent attempts to lower thelanding gear, a clevis pin in the landing gear operating mechanism had fouled against the edge of an access hole ina structural beam and jammed, preventing the landing gearfrom operating. AAIB Bulletin 03/2012, Ref: EW/C2011/07/08
CAA Closure: Nr4 bearing failure (new outer race material) due to outer race spalling area evidences associated with cage rupture and damaged rolling elements. There is no evidence of mis-assembly, no evidence of hard particle contamination, no corrosion and analysis showed that bearing material confirmed conformity. The manufacturer instigated containment actions to increase nr4 bearing reliability.
Damage to RH landing gear, wing and engine. CAA Closure:During the landing roll, the RH main landing gear trailing arm failed causing the RH wing to contact the ground. The a/c veered to the right and came to rest on the grass onthe RH side of the runway. The pilot was uninjured. The reason for the failure of the trailing arm could not be identified due to damage of the fracture surfaces caused by contact with the runway. AAIB Bulletin 02/2012, Ref: EW/C2011/07/06.
CAA Closure: The occupants were on a local flight at 2,500ft when they noticed smoke entering the cabin around the base of the windscreen. The a/c diverted into Coventry Airport, with the intensity of the smoke increasing and affecting visibility, and made a safe landing. The smoke was caused by an internal failure in the alternator regulator. One Safety Recommendation, nr 2012-022 addressed to the European Aviation Safety Agency. AAIB Bulletin 08/2012, Ref: EW/C2011/07/27.
CAA Closure: Although other potential causes for the engine stoppage could not be eliminated from the investigation, the most likely cause, based on the available evidence, was that stiffness of the fuel selector valve and wear on the rod connecting it to the selector handle may have resulted in the valve being in an intermediate position duringthe take-off. This would have reduced the fuel flow to a level too low to sustain continuous engine operation. The suddenness of the engine stopping and the limited time available to react to it probably resulted in the pilot omitting to lower the nose before the a/c stalled. Once the a/cstalled, it is highly unlikely that he could have recovered the a/c in the height available. AAIB Bulletin 04/2012,Ref:EW/C2011/07/05

CAA Closure: The a/c was on approach to land when the engine appeared not to respond to increased power demands. Inthe subsequent forced landing in a field, the a/c flippedonto its back due to the soft soil and stubble. AAIB Bulletin March 2012, Ref: EW/G2011/07/34.
CAA Closure: Investigation found a hard fault with the network interface card and processor (NIC+PROC 1 in MAU1), which was changed. No further reports since.
CAA Closure: Whilst landing at North Weald following a flying display at another airfield, the a/c was observed to fly the approach and subsequent landing with the landing gear retracted, despite warnings from the control tower. The a/c was found with the hydraulic selector lever in the 'U/C down' detent but the MLG was found in the locked 'up' condition. When the a/c was recovered, the foot lever was activated to release the uplock and extension and downlockwas achieved using the hand pump without any anomalies. No faults were found with the engine-driven hydraulic pump,the indicator lights or audio warning, although a detailed investigation of the hydraulic system is continuing. AAIB Bulletin 03/2012, Ref: EW/G2011/08/20
CAA Closure: During the flight, the pilot encountered difficulty trimming the a/c and reported that in order to maintain straight and level flight, a higher than usual powersetting and significant levels of nose-up trim were required. When reducing power in preparation for landing, the control stick became heavy and the a/c pitched rapidly downwards. The pilot was able to maintain control until just prior to flaring, when the nose pitched rapidly up and the a/c dropped to the ground, landing heavily. Post-flight inspection by the pilot revealed that the tail boom had collapsed. The pilot considered that a runaway trim condition may have accounted for the control difficulties encountered during the flight. The repair agency checked the operation of the electrically operated elevator trim tab and although it functioned normally when tested, the trim system was replaced as a precaution. AAIB Bulletin 01/2012, Ref: EW/G2011/09/12
CAA Closure: The engine lost power and its rpm dropped toa low idling speed as the a/c climbed through 900ft aftertake-off. The pilot confirmed the engine controls were correctly selected and declared a MAYDAY. During the subsequent forced landing, the a/c struck bushes at the end of the landing roll causing damage to its propeller, lower wings, elevator and rudder. The pilot was uninjured. The a/c was later recovered to White Waltham Airfield where, at thetime of writing, it was awaiting investigation of the power loss. If the results of this investigation reveal any significant safety information, an addendum to this report will be published. AAIB Bulletin 2/2012 ref EW/G2011/09/19.

CAA Closure: Oil in the engine bay, delivered either by aleak or overfilling during replenishment, plus retractionof the engine without sufficient cooling is the reported cause. The BGA have promulgated notes on retraction process to all ASH 26E owners. The manufacturer has improved drainage and ventilation on later models.
CAA Closure: The a/c was being used as a glider tug. During the take-off run for an aero-tow it experienced a failure within the RH landing gear, causing the RH wingtip to contact the ground. The pilot released the tow and shut down the engine to avoid damage to the propeller. The a/c then turned through approximately 270deg to the right before coming to rest with no further damage. It was found that asteel bracket reacting the RH gear bungee loads had developed a concealed crack, causing the bracket to fail, thereby unloading the bungee and allowing the wheel attachment to migrate upwards. On this occasion, the cable on the RH gear unit functioned as designed and was able to carry thesupport loads following the bracket failure. This limitedthe wheel travel and prevented extensive damage to the a/c. It did not, however, prevent the wingtip from contacting the ground. AAIB Bulletin 03/2012, Ref: EW/G2011/08/24
CAA Closure: The crew were forced to make a wheels-up landing after the landing gear could not be extended by the normal or backup systems. Subsequent examination revealed the reason for the malfunction to be damage to the left gear operating mechanism, but it was not evident what had caused this damage. AAIB Bulletin 08/2012, Ref: EW/C2011/10/03.
CAA Closure: The a/c was on its first flight after maintenance to the RH main landing gear microswitch. The pilot had cycled the gear in flight satisfactorily and was on approach to land. However, on selecting the gear down, only two green lights illuminated. Believing that the microswitch on the RH main gear had shifted, he continued with the landing. After touchdown the a/c's nose dropped, allowing the propeller to contact the runway. The pilot noticed thatthat it was the nose gear green light that was not illuminated. He applied full power and took off again using fullflap, with some vibration. The flaps were retracted and the engine rpm was reduced in the climb out. The pilot cycled the gear twice and obtained three greens, before landing without further incident. Airfield fire service personnel, who had seen sparks during the initial touchdown, attended and the runway was searched and cleared of debris. Thepilot considered that the recent maintenance to the RH gear had caused him to think there was a problem with the right gear, when in fact the problem was with the nose gear.AAIB Bulletin March 2012, ref: EW/G2011/11/06.

CAA Closure: The LH engine lost power during the approachto land when the a/c was configured with the landing gearand flaps extended. The pilot decided to carry out a forced landing in a field and the a/c was extensively damaged during the subsequent heavy landing. It cannot be determined if the use of unleaded MOGAS contributed to the engine failure. The use of this fuel can damage the seals in the a/c and engine fuel system, and cause long-term damage to the engine. The engine is also more prone to carburettor icing, vapour lock and a loss of power due to detonation 'knocking'. The presence of alcohol in the fuel can also damage seals and cause a loss of power. AAIB Bulletin 03/2012, Ref: EW/C2011/12/02
The pilot of a TBM 700 landed with three green lights anda red light showing on the landing gear control and indication panel; the nose gear subsequently collapsed during the rollout. He had interpreted the three greens as indicating that the landing gear was locked down, however the redlight signifies that the gear is unlocked and takes precedence over the three greens. Although the correct procedure required the landing gear to be operated manually using the hand pump, it was dependent on the pilot recognising that a red warning light signifies that the landing gear isunlocked, even if three greens are displayed concurrently. The lack of clarity in the TBM 700 Pilot's Operating Handbook (POH) regarding the significance of the red warning light was considered to be a causal factor in this accident. One Safety Recommendation (2009-002) is made to improvethe clarity of the Emergency Procedures in the TBM 700 POH. CAA Closure: The Recommendation made in respect of this occurrence is not addressed to the CAA and is to be actioned directly by the relevant body. No further CAA action is practicable.
CAA Closure: The a/c engine stopped at low height, shortly after take-off. The pilot turned back to the airfield and attempted a landing on a secondary runway, but the a/c landed heavily, causing damage to the landing gear and forward fuselage. Neither occupant was injured. The cause of the engine failure had not been established at the time of reporting, but fuel starvation was considered by the pilotto be a probable cause. AAIB Bulletin 05/2012, Ref: EW/G2012/02/03.
CAA Closure: During the approach, wisps of smoke were seen to come from the area of the cabin heater selector switch. The system was isolated, the cabin fire extinguisher was discharged and the a/c made an uneventful landing. The source of the smoke and acrid smell was an overheated and partially melted electrical connector. AAIB Bulletin 05/2012, Ref: EW/G2012/02/10.

During the rollout from a three a/c 'stream' landing, thepilot and passenger of the rear a/c had to apply full brake pressure to avoid a collision with the a/c in front. Although the a/c did not collide, the resulting loads experienced by the wing structure supporting the landing gear caused it to fail in overload. Subsequent analysis of the failed structure identified possible manufacturing issues, which may have contributed to the failure. The accident wasalso subject to an RAF Unit Inquiry. Five safety recommendations, nrs 2010-078 to 2010-081 addressed to the European Aviation Safety Agency (EASA) and 2010-082 addressed to the Federal Aviation Administration, have been made. AAIB Bulletin 01/2011, ref: EW/C2009/09/09.
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CAA Closure: On approach to London Heathrow Airport, in IMC and icing conditions, there was a loss of communicationbetween the Probe Heat Computers (PHC) and the Centralised Fault Display System (CFDS). The associated Electronic Centralized Aircraft Monitoring (ECAM) actions required thecrew to select ADR3 as the data source for the commander's instruments. Later, on final approach to R/W27L, the a/csuffered a loss of displayed airspeed information on boththe commander's and the standby flight instruments. The crew carried out a go-around using the 'Unreliable Speed Indication' procedure from the Quick Reference Handbook (QRH). The investigation concluded that the loss of displayed airspeed information resulted from a combination of: □ - aloss of communication between the Probe Heat Computers (PHC) and the Centralised Fault Display System (CFDS), □ - icing of the standby pitot probe resulting in the loss of indicated airspeed displayed on the commander's and standbyinstruments. □ One Safety Recommendation made, 2011-099, addressed to the a/c manufacturer. AAIB Bulletin 04/2012, Ref: EW/C2010/12/04

CAA Closure: On 2 August 2010 the a/c ground looped during a landing at a farm strip. This had occurred previously,on 22 June 2010, to a co-owner. The pilot in the August event reported that only light lateral force was required for the tailwheel to castor freely, with weak centring springs making directional control difficult. With the mechanical problem rectified, the pilot reported the ground handling much improved. The accidents were not reported to the AAIB at the time as the two pilots did not appreciate thatthis is a statutory requirement. AAIB Bulletin 12/2011, ref: EW/G2010/08/21. See also 201014548.
CAA Closure: After take-off, the a/c failed to accelerateand climb. It then hit a hedge at the end of the runway on the airfield perimeter before coming to a stop shortly afterwards. The a/c was damaged but the pilot and passengers were uninjured and vacated the a/c without difficulty. The conditions at the time of the flight were such that there was serious risk of carburettor icing at any power setting. AAIB Bulletin 05/2011, Ref: EW/G2011/01/08.
CAA Closure: An approach was being flown in gusty crosswind conditions. Reverse thrust was selected immediately after touchdown, but the a/c subsequently bounced and the commander decided to go-around. During the go-around the nr2 (right) engine thrust reverser failed to stow, and the engine thrust was maintained at idle by the FADEC system. Thea/c's tail struck the ground during the rotation. The a/cbecame airborne at low speed in a high drag configurationand its acceleration and climb performance did not increase appreciably until 47secs after lift-off. The nr2 enginewas subsequently shut down and the a/c diverted and a single-engine landing was carried out. The nr1 thrust reverser was selected during the landing but did not fully deploy. The investigation found that the most likely reason for the nr2 thrust reverser failure to stow was an intermittent loose connection in the auto restow circuit. It was further determined that conflicting operational guidance exists with respect to selection of reverse thrust and go-around procedures. A number of safety actions have been taken as a result of this serious incident. AAIB Bulletin 05/2012, Ref: EW/C2011/01/03

CAA Closure: During the landing roll the pilots saw cockpit indications of a fire in the baggage compartment. The a/c was taxied clear of the runway, brought to a halt on the taxiway and a PAN call was made requesting the attendance of the emergency services. The pilots carried out the emergency checklist actions, which included discharging a fire extinguisher into the baggage hold, and asked a member of the cabin crew to look into the hold through an inspection hole in the lavatory floor. The cabin crew member reported that the hold "looked cloudy". The commander instructed the passengers to vacate the a/c promptly through the normal exit, leaving cabin baggage behind. The emergency services found no evidence of fire; cloudiness in the hold was thought subsequently to be due to the fire extinguisherdischarge. The operator believed that the incident might have been caused by water ingress into one of the fire detectors. AAIB Bulletin 06/2011, Ref: EW/G2011/02/10.
Hydraulic pipes damaged. Tyre debris also caused some damage to the underside of the a/c. CAA Closure: During an otherwise normal landing at Cardiff, a failure in the RH landing gear freed the axle to oscillate about a vertical axis, leading to severe damage and deflation of both tyres. The original failure was the result of the corrosion induced weakening of a threaded attachment. Consequent overload fracture of another component appears to have taken place before the Cardiff landing. The landing gear manufacturer is introducing a new Service Bulletin to address the deterioration of the corroded and failed area in service and amending the build procedure to obviate the possibility of surface damage during component assembly creating an originfor a corrosion process. A further problem noted during the fleet inspection following the original event has been addressed in the final Service Bulletin. AAIB Bulletin 02/2012, Ref: EW/C2011/04/01.
CAA Closure: The a/c's landing gear warning horn, designed to sound when airbrakes were used with the landing gear not locked down, tested satisfactorily during a pre-flight test. Before landing, the pilot lowered the landing gear in the normal manner by pulling the landing gear latch lever, which locked the single main wheel in either the up or down position, freeing the selector lever which was then put to the 'Down' detent. The warning horn did not sound when he deployed the airbrakes briefly during the approach. The a/c landed normally on the grass landing area, but after a short ground roll the landing gear collapsed, causing damage to the propeller when it struck the ground. The a/c was lifted and the landing gear lowered and locked. After a visual check, the a/c was lowered onto the landing gear and wheeled to a hangar. In his report, the pilot observed that the landing gear latch lever, which was not visible in flight, may have been worn such the main wheel was not locked, but that the warning horn had not indicated the unsafe condition. AAIB Bulletin 11/2012, Ref: EW/G2012/08/26.

CAA Closure: The a/c was slightly fast on final approach, so the pilot decided to go-around. As the a/c started to climb under full power, the engine began making unusual noises and the pilot felt a significant loss of power. He identified an area for landing which, to avoid obstacles and livestock, required a turn to the left, but was unable to land in the selected narrow stretch of ground. With rising ground beyond, he instead landed the a/c at low speed in a substantial hedge that ran alongside. The pilot sustained a minor foot injury but both he and the passenger, who had been wearing full harnesses, were able to vacate the a/c without assistance. At the time of reporting, no reason for the loss of engine power had been established. AAIB Bulletin 11/2012, Ref: EW/G2012/09/01.
CAA Closure: During the approach, the flight crew observed an indication that the RH main landing gear was not in the 'down and locked' position. After completion of the emergency checklist items, the indicator continued to show that the RH main landing gear was unsafe. An emergency was declared and the a/c made an uneventful landing. Rapid disembarkation of passengers carried out. An investigation by the operator revealed that a grease nipple, released from the RH main landing gear lock link assembly, had become lodged on the eye end of the landing gear downlock actuator,preventing the lock from operating correctly. As a resultof this incident the operator has introduced several measures to minimise the possibility of a recurrence. AAIB Bulletin 05/2011, Ref: EW/G2011/11/11.
CAA Closure: The AAIB had previously issued a Special Bulletin S1/2012. The a/c's right main landing gear failed as it landed. The right main landing gear detached, the a/c slid along the runway on its remaining landing gear, right wingtip and luggage pannier before coming to rest on the grass adjacent to the runway. The passengers and crew vacated the a/c without injury. The right landing gear failed as a result of intergranular corrosion/stress corrosion cracking of the forward yoke pintle. Four Safety Recommendations, nrs 2012-024 and 2012-025 addressed to the a/c manufacturer, nr 2012-008 addressed to the European Aviations Safety Agency and nr 2012-026 addressed to the Airport Authority. AAIB Bulletin 10/2012, Ref: EW/C2012/03/03.
CAA Closure: The a/c's engine started misfiring soon after take-off, accompanied by a drop in rpm. There was insufficient height available to make a suitable landing field, and the a/c landed in a pig farm. It struck a pig shelter on landing and overturned. Neither occupant suffered serious injury. The pilot observed that the engine appeared to have started misfiring loudly, which he thought could havebeen due to an ignition or fuelling fault, and that the volume of the misfire did not reduce with reducing rpm. He also did not rule out carburettor icing. There had been insufficient time to attempt a restart or secure the engine prior to the forced landing. AAIB Bulletin 09/2012, Ref: EW/G2012/05/12.

CAA Closure: The a/c's landing gear failed to retract fully on take-off but remained in an unlocked position. The a/c subsequently landed on R/W19 at Oxford (Kidlington) Airport. The gear collapsed, as anticipated by the pilot, and the a/c came to a stop upright, with no injuries to the pilot and minor damage to the a/c and runway. It was reported that initially the salvage crew were not able to extend the right main gear and had found a broken connecting rod in the mechanical linkage. Once this was removed they were able to extend the gear. The condition of the linkage prior to the accident is unknown and it is possible this damage was caused during the landing. AAIB Bulletin 02/2013, Ref: EW/G2012/09/11.
CAA Closure: The aircraft suffered a main landing gear collapse following an uneventful approach to land. It was determined that the left side brace upper arm had suffered a fatigue failure. The failure rendered the side brace ineffective and the unrestrained main trunnion continued to translate outboard, leading to the collapse of the gear. The aluminium brace was found to contain a small metallurgical feature at the crack origin which was consistent with titanium rich particles (TiB2) particles which are introduced as a grain refiner during casting of the billet prior to forging. The size of the feature was within the defined specifications for AL7010-T74. Analysis of the area surrounding the crack origin revealed an area of static loading before propagating a crack in fatigue, indicating that there may have been a single overload event at some point in the history of the side brace upper arm. The aircraft manufacturer determined that failure of the brace late in a take-off run is hazardous under EASA certification specification (CS) 25.1309. AAIB Bulletin 10/2013, Ref: EW/C2012/06/01.
CAA Closure: AAIB downgrade to 'Non-Reportable' from AARFinvestigation. No further investigation to be progressed by the AAIB.

CAA Closure: The right undercarriage collapsed shortly after the a/c landed as a result of a nut having pulled off the forward outboard attachment bolt. The nut, which had also bottomed out on the bolt thread, was manufactured from a softer steel alloy than the bolt. The LAA had previously taken appropriate action to advise their members and inspectors on a number of issues that might affect the integrity of the undercarriage attachment bolts fitted on Jabiru a/c. The safety action that the LAA initiated as a result of this accident will reinforce this message and the mandatory use of AN6 bolts should help to reduce the number of failures of the undercarriage in the future. The LAA is also reviewing the circumstances surrounding the painting, weighing and Permit renewal of the subject a/c and will use their findings to inform their members on the necessity to weigh a/c after they have been painted and the correct procedures to follow. AAIB Bulletin 03/2013, Ref: EW/C2012/08/07.
CAA Closure: A small valley lies across the approach to the airstrip and, typically, causes an area of sink, which was anticipated. However, as the pilot opened the throttle, the engine did not respond. The a/c was unable to clear a hedge in the undershoot, so the pilot raised the nose of the a/c just prior to impact. The underneath of the a/c struck the hedge before it came to rest on the grass runway beyond. The pilot secured the a/c and he and his passenger vacated it, uninjured. There was no fire and no oil or fuel leaks. At the time of reporting, the cause of the loss of power had not been established, but the a/c throttle was found to have been in the fully open position. A person nearby heard the engine rpm increase after full flap was lowered, but then no other engine noise before impact. AAIB Bulletin 01/2013, Ref: EW/G2012/08/20.
CAA Closure: During a test flight for the initial issue of a Permit to Fly, the pilot reported a loss of pitch control authority during a go-around from low speed. On the subsequent approach the pilot delayed lowering the landing gear to ensure he could land on the airstrip, but it was not fully extended by the time the a/c touched down and the gear collapsed during the landing roll. Prior to the flight 50% of the length of the elevator trim tab Gurney flap had been removed to correct a perceived problem of limited forward elevator authority during cruise, and post-accident inspection revealed that the elevator cables had low tension. After repair the a/c was test flown by the LAA's Chief Test Pilot, who considered the design was acceptable without further change. AAIB Bulletin 04/2013, Ref: EW/C2012/08/08.

CAA Closure: The microlight a/c was on a check flight forthe Permit to Fly revalidation. After take-off the enginelost power and the pilot carried out a forced landing. The a/c landed in a field, just short of the R/W34 thresholdat Otherton Airfield. There were no injuries but the a/c sustained damage to the nosewheel. Subsequent examination of the a/c revealed that a fuel strainer, normally attached to the outlet at the bottom of the fuel tank, was loose in the tank and was also clogged with a "tar-like" substance. The pilot considered that the a/c may have been storedwith fuel in the fibreglass tank, leading to degradation of the tank material, blockage of the strainer and subsequent fuel starvation. He considered that the fuel strainer may have come loose during removal of the tank. AAIB Bulletin 09/2012, Ref: EW/G2012/04/11.
CAA Closure: On final approach the pilot found that therewas a crosswind of about 10kts from the left. The a/c made a heavy landing and bounced twice, before the pilot elected to go-around. On the second approach, which was well executed, the a/c touched down on its mainwheels first but,when the nose was lowered, the nose landing gear collapsed and dug into the ground, flipping the a/c onto its back.The pilot, who was uninjured, managed to climb out unaided and raised the alarm. He assumed that the first, heavy, landing had damaged the nose landing gear which failed on the second, normal, touchdown. AAIB Bulletin 09/2012, Ref:EW/G2012/05/11.
CAA Closure: Upon touchdown, the left landing gear seemedto receive a small 'thump' and the a/c rolled to an abrupt stop in about half the usual landing distance, during which it pitched forward onto its nose. The propeller broke and the engine, which was at idle power, stopped. The pilot secured the a/c and vacated normally. It was evident that the left landing gear leg had failed and that the wheel no longer tracked correctly. The pilot surmised that the leg had been subject to an undetected sideways load or thatthe wheel had caught a rut or hole at touchdown. However,there had been no appreciable crosswind and a strip inspection revealed no obvious irregularities. AAIB Bulletin 09/2012, Ref: EW/G2012/05/19.
CAA Closure: Investigations found no historical reports of brake not working and no reports of wear found on Annualinspection. During this incident, the spline slipped during a hard actuation and made the lever crank angle ineffective. Pilots will be advised to check the effectiveness ofthe wheel brake and report any unserviceability. This will be highlighted in a BGA Technical News Sheet.
CAA Closure: The a/c's left inboard fuel drop tank detached during landing. A technical investigation by the a/c operator established that insufficient clearances and free play within the tank release mechanism created a situation whereby the drop tank could detach with a relatively small externally applied force. AAIB Bulletin 02/2013, Ref: EW/G2012/09/26.

CAA Closure: The pilot made a normal approach to R/W09, with both a green light and a mechanical indicator confirming that the landing gear was locked down. As the pilot lowered the nose after touchdown, he heard and felt an impact. He immediately pulled back on the control column to keep the nose off the runway, while steering with rudder and brakes. Eventually, the nose dropped fully to the ground and the a/c slid to a halt on the runway, about 45deg offset from the centreline. The pilot, who was uninjured, secured the a/c and vacated it. This required going forward from the cabin door and over the wing, as the rear step was too high off the ground. The pilot reported that the nose landing gear had suffered a mechanical failure. A knowledgeable witness in the control tower had reportedly observed the landing gear to be down prior to landing, and saw the nose gear collapse after a short ground roll. The reason for the failure of the nose landing gear has yet to be established. AAIB Bulletin 01/2013, Ref: EW/G2012/09/16.
CAA Closure: The landing was normal until near the end of the landing roll when wheel braking was applied. The gear warning horn sounded and, two or three secs afterwards as the a/c was travelling at about 15kts, the nose landing gear gently moved towards the retracted position. The a/c's nose lowered to the ground and both propellers contacted the runway. The a/c came to a stop within about 20m and the pilot secured the a/c. The five occupants were uninjured; they vacated the a/c through the cabin door as the airfield emergency services arrived. The a/c was checked by a local maintenance and repair organisation, which found no faults with the undercarriage system. Several retraction/extension cycles were carried out, on each occasion achieving positive downlock and green indicator lights for all three undercarriage legs. The cause of the accident was thus unresolved. AAIB Bulletin 01/2013, Ref: EW/G2012/09/23.
CAA Closure: Whilst climbing out after take-off, the pilot heard a thud and saw that the landing light cover on the left wing leading edge had failed. He experienced severe control difficulties and an attempted forced landing back at the airfield resulted in the left wing striking the ground, slewing the a/c to a halt on the grass. The landing light cover had been made using an inappropriate method. AAIB Bulletin 03/2013, Ref: EW/G2012/10/13.
CAA Closure: The engine lost power on go-around, landing on soft ground causing damage to the a/c. Further investigations on the engine showed no further problems, however a fouled spark plug may have contributed to this event. Unable to establish root cause and due to the resultant damage to the propeller, crankshaft and crankcase, it was impossible to determine if there were any other contributing factors. The a/c is to be rebuilt.

CAA Closure: Whilst in the circuit to land, the pilot found the throttle had jammed in the fully open position. When approaching on finals, his efforts to free the jam resulted in the throttle becoming stuck at idle. The landing gear would not extend and the pilot landed wheels-up on the grass. It was found that an exhaust pipe weld had fractured, releasing hot gases into the engine bay and causing damage to several components. The LAA has advised that they intend to conduct a review of the design of the exhaust system, since it is thought that the failure probably occurred following a period of crack development, which went undetected. For the same reason they will also look at the ease of access to the area for frequent inspections for defects such as this. The LAA give the general advice to pilots about to fly an a/c with which they are unfamiliar, that they receive a full briefing, and understand all the a/c systems, before they take to the air. AAIB Bulletin 05/2013, Ref: EW/G2012/10/15.
CAA Closure: Approaching Sherburn, pilot descended from 4,500ft to 2,500ft and selected landing gear down; he observed a red ‘gear unsafe’ indication but did not mention in his statement if there were any green ‘down and locked’ indications. He reselected the gear but to no avail, but then he became aware of smoke emanating from under the seats. He wanted to reduce engine power but ‘in panic’ pulled the propeller rpm lever instead. This action meant that the engine rpm would not exceed 2,000 even with full power and because of this he decided to conduct a forced landing in a field near his destination. During the landing the a/c was severely damaged but the pilot and his passenger were uninjured. It is possible that the smoke the pilot saw had come from the electro-hydraulic landing gear motor, but this has not been confirmed. During the event he made no attempt to use the emergency extension facility which would have released hydraulic pressure in the system and allowed the gear to lock down under gravity. AAIB Bulletin 03/2013, Ref: EW/G2012/11/02.
CAA Closure: AAIB downgrade to 'Non-Reportable' from AARF investigation. No further investigation to be progressed by the AAIB.
CAA Closure: The a/c’s engine began running abnormally soon after take-off, so the pilot carried out an immediate return and landing. The landing was fast and heavy, and the a/c bounced and pitched fore and aft before the nosewheel dug in to soft ground, causing the a/c to flip over. One of the two occupants suffered minor injuries. At the time of reporting, the reason for the abnormal engine running had not been established, although the pilot thought carburettor icing was unlikely given that the a/c was equipped with a water jacket carburettor heating system. AAIB Bulletin 03/2013, Ref: EW/G2012/11/06.

CAA Closure: After the aircraft had taken off from a private strip, the pilot was unable to retract the landing gear or, subsequently, obtain down-and-locked indications. Anticipating that the gear was not fully locked down, he continued to his destination where the left main and nose landing gear legs collapsed following the touchdown. It is thought that maladjustment of the landing gear mechanism had caused failure of a main gear screwjack during the take-off. A number of recommendations on this subject have been drawn up by the LAA for discussion with the aircraft manufacturer. AAIB Bulletin 07/2013, Ref: EW/G2012/12/08.
CAA Closure: The pilot reported that he selected the landing gear down and saw the main gear lower as normal. However, he did not see a green ‘gear down’ indicator light until he cupped his hand around the indicator, after which he did see the light. Just before touchdown, he heard the ‘landing gear unsafe’ warning horn, but ignored it, assuming it to be the stall warning horn. The a/c continued to pitch nose-down after landing and the propeller struck the ground. It slid to a stop on the hard surface runway without the need to apply wheel brakes. Photographs taken at the scene showed the nose landing gear to be still retracted with the gear doors closed. A reason for the nose landing gear failing to lower had not been established at the time of this report. AAIB Bulletin 03/2013, Ref: EW/G2012/12/05.
CAA Closure: The pilot was unable to extend the nose landing gear, despite several attempts. A successful forced landing on the grass at Stapleford was carried out. It was thought that wear in the nose gear door mechanism had caused the nose gear to jam. AAIB Bulletin 04/2013, Ref: EW/G2012/12/04.
CAA Closure: Whilst climbing after take-off, the crew noticed a loud rumbling noise together with a small amount of vibration and observed an Exhaust Gas Temperature (EGT) exceedance on the RH engine. Having performed all the appropriate drills, it appeared that all engine parameters were normal but the crew nevertheless decided to return. Following an uneventful overweight landing, inspection showed that a large amount of the RH engine inboard thrust reverser inner wall structure was missing and the engine nozzle was damaged. This was the fifteenth similar occurrence known to the manufacturer and a number of inspections and modifications were already in place to try to mitigate inner wall damage and potential parts liberation. The aircraft manufacturer has advised that replacement of the thrust reverser inner wall will be required, and may be mandated, for all affected aircraft. AAIB Bulletin 08/2013, Ref: EW/G2012/12/10.

CAA Closure: Two subject aircraft type suffered detachment of a propeller counterweight assembly during initial climb severely damaging the corresponding propeller blade. Successful forced landings were completed in both cases. Evidence from the second event suggested that the failure was caused by an issue concerning the method of installation of the counterweight assemblies on the affected propeller blades. Since the airframe/engine/propeller combination is unique to this fleet, the AAIB has shared its investigation findings with both the propeller manufacturer and the operator to enable them to develop a ‘return-to-service’ strategy. AAIB Bulletin 11/2013, Ref: EW/C2013/01/01.
CAA Closure: The student pilot was preparing to take-off on his first solo flight. The first attempt was abandoned because he felt that the engine power reduced during the take-off roll. On the second attempt, the aircraft became airborne but the engine lost all power at about 300ft. The aircraft force-landed within the airfield perimeter and its nose landing gear collapsed. The instructor commented that he had high regard for his student’s flying skills, particularly his handling of the ‘engine failure after takeoff’ drill. His only regret was that, had he known the reason for aborting the first take-off, he would have instructed the student to abandon the sortie. He states that his organisation has reiterated to all pilots flying with them that they must cancel their flight and return should any problems be experienced prior to take-off. At the time of the Bulletin, no reason for the engine failure has been established. AAIB Bulletin 06/2013, Ref: EW/G2013/02/06.
CAA Closure: The aircraft had just gone around because the pilot felt that his groundspeed was too high. As the aircraft turned onto the crosswind leg, the engine stopped suddenly. The subsequent forced landing in a field adjacent to the airfield was successful but the right wing was damaged when it struck a sheep although the animal did not appear to have been injured. There was no immediately obvious reason for the engine failure but the maintainer of the aircraft has commented that the weather conditions were conducive to carburettor icing. AAIB Bulletin 07/2013, Ref: EW/G2013/04/03.
CAA Closure: The aircraft bounced slightly on landing. The pilot opened the throttle to assist with controlling the aircraft, but the engine did not respond. After a series of pitch excursions, the nose landing gear collapsed and the aircraft inverted. AAIB Bulletin 07/2013, Ref: EW/G2013/04/16.
CAA Closure: The engine stopped abruptly and the aircraft landed in a fallow field close to the runway, during which the nose landing gear collapsed. The pilot commented that the nature of the engine stoppage suggested fuel starvation, but an examination immediately after the accident found sufficient fuel onboard and no fuel system defect. The builder of the aircraft has undertaken to advise the AAIB of the results of an engine run. AAIB Bulletin 08/2013, Ref: EW/G2013/04/04.

CAA Closure: As the nosewheel contacted the ground on touchdown the nosewheel and yoke assembly detached from the aircraft. The aircraft veered off the runway and came to a stop with a nose-down attitude. There were no injuries to the crew or passengers. The nose landing gear had fractured across the plated portion of the oleo. A forensic examination of the damaged nose landing gear assembly is being carried out by the manufacturer. AAIB Bulletin 11/2013, Ref: EW/G2013/05/02.
CAA Closure: After take-off the pilot was informed that a tailwheel assembly had been found on the runway. A flypast of the control tower confirmed that the aircraft's tailwheel was missing. The pilot subsequently made an uneventful landing. Examination of the aircraft revealed that the bolt attaching the tailwheel assembly to the fuselage was missing. The bolt is located behind a fairing in the rear fuselage and is therefore not visible during pre-flight checks. There is no requirement to carry out a scheduled inspection of the tailwheel mounting structure. As the bolt was not recovered, the reason for the failure could not be determined. AAIB Bulletin 08/2013, Ref: EW/G2013/05/05.
CAA Closure: The aircraft departed from a private, grass strip and at about 40ft engine note changed, with some rough running and a noticeable reduction in power. The pilot landed straight ahead in an adjacent grass field which had an uneven surface. During the landing roll the landing gear and nose were damaged. No explanation for the loss of power was identified and a post-accident inspection of the fuel revealed no water. At the low height and airspeed a straight ahead landing was the only option. AAIB Bulletin 08/2013, Ref: EW/G2013/05/10.
CAA Closure: During take-off, the nose landing gear oleo and nosewheel detached from the aircraft. The pilot reported that the take-off was normal, except that he had felt a minor "bump" through the rudder pedals at rotation. After discussions with the Chief Flying Instructor on the VHF radio, a decision to divert was made. After making a practice approach the pilot selected the engine, fuel and battery 'OFF' on short final and landed on the foam covered runway. The aircraft remained upright and the pilot and passenger, who were uninjured, were able to vacate the aircraft normally. The pilot reported that the upper part of the torque link appeared to have failed and that the lower part of the link was found still attached to the lower oleo assembly. The maintenance organisation confirmed that the circlip which located the oleo into the leg was found with the detached oleo and it appeared that the failed torque link had allowed the oleo drop out as the aircraft became airborne. The reason for the upper torque link failure had not been identified. AAIB Bulletin 10/2013, Ref: EW/G2013/05/18.

CAA Closure: Shortly after take-off, at a height of about 50ft, there was a sudden vibration, which was severe enough to prevent the pilot reading his instruments. The vibration then stopped, combined with a complete loss of engine power. The pilot jettisoned his glider and manoeuvred the aircraft for a forced landing in fields beyond the airfield boundary. The aircraft ran into a hedge and pitched nose-down, flipping over onto its back and coming to rest inverted. The pilot, who was wearing a full harness, was uninjured and was able to vacate through the aircraft's door. At the time of the report, the reason for the engine failure was awaited. AAIB Bulletin 08/2013, Ref: EW/G2013/05/15.

CAA Closure: AAIB downgrade to 'Non-Reportable' from AARF investigation. No further investigation to be progressed by the AAIB.

CAA Closure:

The pilot lost yaw control of the helicopter as it approached the final stage of a decelerating transition to a hover. Examination of the helicopter established that hydraulic fluid leaked from two unions securing hydraulic pipes to the tail rotor hydraulic servo. The leak depleted the hydraulic contents to the extent that a loss of system pressure occurred. Prior to the accident, no evidence of a hydraulic fluid leak had been observed by either the pilot or maintenance personnel, so it is reasonable to assume that the unions became loose at some point during the accident flight. When hydraulic system pressure was lost, the loose unions would have allowed the pressure within the tail rotor load compensator to dissipate. This would have resulted in an immediate loss of assistance to the yaw controls and an increase in the force required by the pilot to maintain directional control. The presence of fluid within the hydraulic system would have prevented the loss of pressure in the main rotor load compensators, allowing hydraulic assistance of the main rotor controls to be maintained for a period. Detailed testing established that full control of the tail rotor remained available albeit without hydraulic assistance. The higher control loads associated with an immediate and unexpected loss of hydraulic

CAA Closure:

The left main landing gear leg failed at low speed during the landing roll. There were no injuries. The aircraft was inspected by a local maintenance organisation who reported that the leg had failed approximately 3 inches below its top attachment. The engineer who conducted the inspection commented that evidence of corrosion was visible on the inner surface of the leg and he thought this may have led to the development of a crack from the inside outwards. He added that the area was difficult to inspect visually in situ. AAIB Bulletin 12/2013, Ref: EW/G2013/07/04.

CAA Closure: Climbing through about 200ft after take-off from R/W27 at Boston, and whilst banked to the right, the microlight's engine failed. The pilot turned right towards a playing field north of the runway but assessed the aircraft would not be able to clear a dyke beforehand. He therefore turned further right, back towards the runway, but was unable to clear a second dyke that ran parallel to the runway on its northern side. The aircraft struck the top of the dyke and rolled forward onto the airfield, coming to rest beside the grass runway. The weather conditions were fine and warm, with a temperature of about 28deg. The pilot thought this may have led to vapour lock which disrupted the fuel supply to the engine. AAIB Bulletin 09/2013, Ref: EW/G2013/07/12.
CAA Closure: The aircraft was landing at its home field. After one practice touch-and-go and a go-around due to another aircraft in the circuit, the aircraft landed wheels-up because the gear electric actuator fuse had blown. The pilot had not noticed that the green indicator lights were not lit on the approach. AAIB Bulletin 11/2013, Ref: EW/G2013/07/21.
CAA Closure: While flying in the local area the pilot heard a loud bang from the rear of the aircraft followed by a loss of thrust. After completing an uneventful forced landing, the pilot discovered that the propeller shaft had failed and the propeller had departed from the aircraft. No other damage to the aircraft was reported. The cause of the failure could not be determined due to the loss of the propeller shaft. AAIB Bulletin 01/2014, Ref: EW/G2013/07/34.
CAA Closure: The pilot was landing at a grass strip in fine weather conditions. The landing was entirely normal until after about 40 or 50m of ground roll the single main landing gear collapsed, causing damage to the propeller when it struck the ground. On inspection, it was apparent that the main landing gear had become unlocked. The precise reason for this had not been determined at the time of reporting, but the pilot suspected that age and wear of landing gear components may have been factors. AAIB Bulletin 10/2013, Ref: EW/G2013/08/03.

CAA Closure:

The aircraft was flying circuits but on the downwind leg of the second circuit the engine stopped and appeared to windmill. The pilot turned the aircraft into wind and selected a field for a forced landing. Unfortunately, the aircraft overran and struck a fence, hedge and small trees, tipping onto its nose and coming to rest in a vertical, nose-down attitude. Two anomalies were subsequently found which could have caused the engine to fail. Contaminated fuel was drained from the filter bowl and three of the four bolts which secured a timing gear to the crankshaft were found to have failed and exhibited extensive high cycle fatigue. It could not be confirmed which mechanism had caused the failure. AAIB Bulletin 04/2014, Ref: EW/G2013/08/02.

CAA Closure: The pilot performed his usual checks and noted that all the instruments gave normal readings; he also had more than sufficient fuel onboard for the flight. He took off using maximum engine rpm but at a height of approximately 250ft, the engine stopped abruptly. The pilot realised that he could not safely alter his heading substantially, so he searched ahead for a suitable field. The first field he saw was growing tall rape but the one after that contained wheat, which the pilot thought looked preferable for a forced landing. However, there was insufficient height for the aircraft to glide to the second field and it landed in the rape, coming to a rapid halt as it did so. The aircraft remained upright and the pilot was uninjured. The pilot is uncertain of the cause of the engine failure but notes that the carburettor bowl was dry and the propeller very stiff to turn, possibly because of fuel (and therefore also lubricating oil) starvation of this two-stroke engine. AAIB Bulletin 11/2013, Ref: EW/G2013/07/33.

CAA Closure:

After takeoff, at a height of about 300 ft, the pilot sensed the engine rpm drop to around 4,000 to 4,500 from its normal maximum rpm of about 6,500. This was insufficient to maintain level flight and so the pilot turned into wind and chose a suitable field. As he approached the field, he realised that he was very close to a hedge which bordered it, so he tried to turn to the right to land parallel to the hedge. The aircraft stalled at a height of about 10 ft and the nose dropped to the left, hitting the ground and collapsing the nose landing gear. The pilot acknowledged that, in addition to the unfortunate timing of the engine power loss, he had allowed the aircraft to become slow, and he could have chosen a more suitable field to land in. Although he intends to do a thorough investigation of the engine and fuel system, at the time of preparation of this bulletin no obvious reason for the power reduction had been found. AAIB Bulletin 01/2014, Ref: EW/G2013/08/07

CAA Closure: The aircraft was performing a steep turn to the left when the engine stopped. It entered a spin and, whilst the pilot was able to recover from the spin, during the subsequent forced landing the aircraft struck a grass bank and was extensively damaged. Both occupants were seriously injured. It was reported that the engine had been consistently reliable. No reason for the engine failure was identified. AAIB Bulletin 12/2013, Ref: EW/G2013/08/13.
CAA Closure: □ The pilot was practising visual circuits and was climbing away after a touch-and-go landing when the aircraft's engine was heard to falter. The aircraft was seen to slow in a climbing attitude before stalling and entering a vertical dive from which it did not recover. The pilot was fatally injured. The engine appears to have faltered at about 500 ft aal. The sudden power reduction, the pilot's relative inexperience and the limited time available to react appropriately are likely factors in the pilot not lowering the nose before the aircraft stalled. There was then insufficient height available for the pilot to effect a recovery from the stall before ground impact. No definitive cause of the engine power loss could be determined. AAIB Bulletin 06/2014, Ref: EW/C2013/08/04.
CAA Closure: Approximately 15mins into an uneventful flight, the engine started to make a loud, unusual noise and lost power. The pilot managed to use the limited power available to position the aircraft for a landing in the only suitable field in the immediate vicinity. The field was approximately 200m long and 100m wide, and bounded by a 2m high dry stone wall. Electrical overhead cables ran diagonally across the field in which a herd of cows was grazing. During the landing, both mainwheels broke off the stub axles. Following the accident the owner found a large number of small fragments of metal in the oil drained from the engine sump and assessed that the loss of power was probably due to an internal mechanical failure. At the time of the accident the aircraft and engine had flown approximately 137hrs. The damage to the landing gear and bends in the main fuselage tube wing spars were consistent with the aircraft having landed heavy. The damage to the aircraft was assessed as beyond economic repair. AAIB Bulletin 11/2013, Ref: EW/G2013/08/37.

CAA Closure: During the final approach, the pilot became aware that the aircraft was descending below the normal approach path and that the engine was not developing the usual level of power. The engine failed to respond to throttle movement and the aircraft continued to descend below the approach path. The aircraft stuck a signal post which was positioned just outside the airfield perimeter fence and came to rest within the airfield boundary. The pilot was unhurt and left the aircraft unaided. Several other pilots who had flown the aircraft had experienced similar low power events which had been attributed to carburettor icing. The pilot also attributed this incident to carburettor ice formation during the later stages of the flight. The weather conditions at the time of the incident were conducive to the formation of carburettor icing at cruise or descent power settings. AAIB Bulletin 11/2013, Ref: EW/G2013/08/39.

CAA Closure:

Whilst on final approach, the crew lost visual reference with the runway and commenced a go-around. During the missed approach momentary blanking of the electronic flight instrument system (EFIS) displays occurred but the standby instruments continued to operate normally. During the subsequent approach a similar event occurred, but only the co-pilot's displays were affected. The crew diverted where the weather was better. During the diversion VHF communication difficulties were experienced, but the aircraft landed without further incident. The operator, in consultation with the aircraft manufacturer, determined that the right EFIS display blanking was caused by a loss of electrical power to the right essential busbar. The right power distribution unit was removed and sent to the manufacturer for investigation. The aircraft manufacturer considers that the transient blanking of the left EFIS displays was caused by an unrelated failure of the 'transzorbs'. (These are installed in the windscreen heat system to protect avionics equipment from the effects of windscreen static). The VHF communication difficulty was explained by a separate fault on the left communication unit. The right communication unit was unpowered as a result of the right essential busbar failure. AAIB Bulletin

CAA Closure:

On the late downwind leg to land, the pilot sensed that the engine was not running smoothly and had “missed a couple of beats”. Carburettor heat had been applied, and he suspected carburettor ice might be responsible, so he executed a precautionary high approach. A successful landing was carried out but, as the aircraft came to a halt on the runway, the engine stopped and smoke could be seen emerging from the upper engine cowling on the right side. His passenger jumped out and could see a small fire coming from the underside of the cowling, which he quickly extinguished using the on board fire extinguisher. The cowlings were removed and a lot of sooting and fire damage could be seen. On switching on the electrical fuel pump, fuel could be seen pouring from the underside of the carburettor. The maintenance organisation visited the aircraft two days later and removed the carburettor, which they took back to their workshop for testing. They were unable to reproduce the leak and a strip inspection did not find any defects. They believe that a transient case of the float sticking may have caused overfuelling of the carburettor. AAIB Bulletin 04/2014, Ref: EW/G2013/09/12.

CAA Closure:

The student pilot was undertaking solo circuit practice with his instructor observing from the ground. He had performed one takeoff and landing and backtracked to take off again on Runway 22. The weather was good with a slight south-westerly wind. Having performed the normal pre-takeoff checks, the takeoff was normal until, having cleared the airfield and at a height of about 300 ft, the engine vibrated and stopped. The pilot attempted to restart the engine but it would not turn over. He switched off the fuel and electrical power and concentrated on finding a suitable landing site. The subsequent touchdown in a grass field was successful but, in the last few metres of landing roll, the aircraft struck a small drainage ditch, causing damage to the landing gear and underside of the fuselage. The cause of the engine stoppage has not currently been determined. AAIB Bulletin 02/2014, Ref: EW/G2013/10/03.

CAA Closure:

The pilot noticed that the engine turbine temperature had increased to close to its maximum limit and prepared to make a precautionary landing. During the approach the indication returned to normal, so he decided to continue the short distance to his destination. As the helicopter climbed away, the engine failed. The pilot carried out a forced landing during which the tail boom struck the ground. He candidly commented that, on reflection, it would have been better to continue with the precautionary landing, rather than having to attempt a forced landing without power from low altitude. He added that in the final stages of the approach he probably flared too much, causing the tail boom to strike the ground. The engine failure appears to be as a result of the disintegration of the No 7 bearing, which was most likely caused by oil starvation. This bearing supports part of the turbine assembly and therefore relies on oil flow for cooling, as well as lubrication. Any reduction in oil flow could lead to the bearing overheating and ultimately failing. AAIB Bulletin 07/2014, Ref: EW/C2013/10/02.

CAA Closure:

The aircraft overran the end of the runway, travelled through a fence and across a road, before coming to rest in a field. The aircraft was substantially damaged in the accident but the pilot was not injured and was able to vacate the aircraft unassisted. The pilot joined the circuit via the base leg for Runway 06 but the Air Ground (A/G) operator requested that he carry out a go-around, because he was close to another aircraft in the circuit. The pilot increased power and went around but reported that both engines then started to “run rough” and he was unable to maintain height. He turned onto the crosswind leg early and advised others, on the radio, that he had two rough running engines. The A/G operator acknowledged this and notified the aerodrome RFFS. The pilot checked the fuel selector and attempted to resolve the rough running by adjusting the throttle, the mixture and the carburettor heat, but without apparent improvement. He turned onto final approach at around 350 ft aal, maintaining a higher than usual airspeed of 85 kt to 90 kt, and made a ‘finals’ call. The A/G operator observed the aircraft, low on final approach. As it floated down the runway, the pilot decided he would not go-around because there might not be

During initial climb just after thrust reduction, packs were put on and the FO noticed immediately fumes. The Captain said that it might be the pollution layer at 4000ft, but after a few mins all flight crew were convinced that it was not any pollution smell but actual fumes from the aircraft. The cabin manager was sent to the cabin to inspect, the situation was the same as it was in the flight deck. At that point flight crew put the oxygen masks on, started the initial smoke drill. As it was under control, and no passengers on board, they did not feel that they had to rush back on an emergency and were satisfied to return back on a priority. ATC was informed. The cabin crew put the smoke hoods on as they were not happy with the potential health risk of not having them on and Captain accepted. A NITS brief was given to the cabin manager. In the process they tried to troubleshoot and as soon as pack flow was put on high as instructed by the QRH, the fumes increased so they turned it back to low flow and just left it until after landing. After landing the duty pilot, MOC and Ops were informed. All crew went to hospital to have a blood test taken.

CAA Closure:

Since 13 October 2013, the pilot and aircraft had only flown for 45 minutes when three days before the accident the pilot carried out the annual air test on the aircraft during which he flew a number of circuits. On the day of the accident the pilot intended to fly a number of circuits before repositioning the aircraft to another airfield. The aircraft had sufficient fuel onboard and prior to the first takeoff, from Runway 08, the engine power check was carried out and found to be satisfactory. The first circuit, which culminated in a full stop landing, was completed without incident. The pilot back-tracked down the runway and took off to fly a second circuit. The acceleration was normal and as the aircraft reached a height of approximately 100 to 150 ft the pilot raised the flaps and at about the same time the engine stopped, though the propeller continued to windmill. Immediately ahead of the aircraft was a field containing crops, with the furrows at approximately 90º to the runway heading. The pilot was concerned that if he attempted to land in this field the aircraft might flip onto its back and given that the aircraft had a bubble canopy he risked being trapped with the possible danger of the aircraft catching fire. He

File number	UTC date	Location of occ	Headline	Narrative text
200401662	18/03/2004	TIGER	UK AIRPROX 25/2004 - A321 and B767 at FL120 at TIGER. SMFactivated.	The B767 was outbound from Heathrow following a DVR 4G SID. The A321 was inbound to the BIG stack. The B767 called climbing to 6000 feet and was given climb to FL100 and then FL120. The A321 called descending to FL150 and was instructed to descend to FL140 and then FL110. At that timethe two a/c were on virtually reciprocal tracks and 10.3nm apart. The A321 passed 900 feet overhead the B767 with a lateral separation of only 0.16nm. The incident will besubject to assessment by UKAB. CAA Closure: Appropriate local ATC action taken.
200401709	21/03/2004	London-Heathrow - LHR	UK AIRPROX 35/2004 - Military helicopter and a B757 4 DMEfrom Heathrow R/W27R at 1000ft.	Military helicopter inbound to Northolt had deviated fromthe Helilane H10. When controller saw helicopter go off route, it was instructed to make an immediate right turn torejoin the route. Separation was lost as soon as militaryhelicopter left the route behind the landing B757. Traffic info was also given to an inbound A319. SMF activated. CAA Closure: Military flight crew error. No further CAA action possible. This AIRPROX will be subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200401724	22/03/2004	AMMAN	UK AIRPROX 39/2004 - B747 and military jet at AMMAN at FL290.	London MIL requested CAS crossing clearance at AMMAN for a military a/c against the B747. At the time the B747 wasclimbing to FL280. The LACC S5/8 Planner misunderstood the co-ordination, believing that the military controller was going to separate the two a/c laterally i.e. by 5nm. However, the military controller's intention was to separate the two a/c laterally until the military a/c reached FL290, when vertical separation would exist. The Planner informed the Tactical Controller and trainee that the military a/c would avoid their traffic. Consequently, the B747 was climbed to FL340 and into confliction with the militarya/c. Action was taken by both sides to resolve the confliction. Minimum separation was 3.5nm/800ft, which occurred after the two a/c had passed. The incident will be subject to assessment by UKAB. CAA Closure: Appropriate ATC personnel action taken.
200401801	24/03/2004	Compton (CPT)	UK AIRPROX 27/2004 - Military jet and an A321 9nm SW of CPT at FL120. Controller descended the A321 to the same level that he had previously climbed the military jet.	The controller climbed the outbound military jet underneath another southbound departure. The A321 reported on frequency descending to FL140 and the controller had planned to climb the outbound military jet underneath the A321 until their tracks had passed. However, he climbed the military jet to FL120 and also cleared the A321 to descend to FL120. On recognizing the confliction the military jet wasinstructed to descend to FL110 and the A321 was given an avoiding action turn to the right. CAA Closure: ATC error. Appropriate local ATC remedial action has been taken as a result of this AIRPROX. The AIRPROX will now be subject to a review by the United Kingdom AIRPROX Board (UKAB).
200402234	09/04/2004	White Waltham	UK AIRPROX 45/2004 - C172 and CL600RJ in the vicinity of White Waltham at 3000ft.	The C172 infringed the London TMA (Class A) and lost separation with an inbound CL600RJ, which was given traffic info and avoiding action. STCA activated. The pilot's report indicates that he failed to note on his chart, whilst flight planning, that there was a requirement to be below 2500 feet abeam White Waltham. CAA Closure: Appropriate CAA licensing action has been taken as a result of this AIRPROX. This AIRPROX is subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200402768	01/05/2004	Inverness (INS)	UK AIRPROX 63/2004 - A319 and military motor glider 10nmsfrom Inverness at 2500-3000ft.	Whilst engaged in their IFR VOR/DME procedure, the A319 pilots did not detect the presence of the Vigilant motor glider as they flew around the 10nm DME arc. The TCAS on theA319 did not detect the presence of the motor glider either. The pilot of the motor glider saw the airliner as it descended towards his aircraft, and elected to turn away from it. This occurrence was the subject of a separate investigation by the UK Airprox Board. CAA Closure: No furtherCAA action required.
200403352	25/05/2004	Lambourne (LAM)	UK AIRPROX 97/2004 - CRJ descended below its cleared FL100, into conflict with an MD82. STCA activated. Avoiding action and traffic info was given to both a/c.	MD82 received a TCAS TA. The CRJ was cleared to descend to FL100, which was read back correctly. On the next frequency the a/c did not report its cleared level, which was not challenged by ATC. The CRJ was observed descending through FL96, coming into conflict with an MD82 holding below at FL90. The CRJ reported it was descending to FL60. Avoiding action was issued to both a/c, with separation reducingto 2.5 nm/600 ft. The operator has been alerted, and has taken appropriate internal action to highlight the incident to all crew. This occurrence is the subject of a separate review by the UK Airprox Board. CAA Closure: No furtherCAA action required.
200403633	03/06/2004	ALVIN	UK AIRPROX 107/2004 - A321 and military a/c at ALVIN above the Swindon corridor at FL240.	The A321 pilot had reacted to a TCAS TA by commencing a descent below his cleared level but did not inform ATC of this manoeuvre. The controller then noticed non-corridor military traffic approaching the Airway at FL230 and, shortly afterwards, it was observed to commence a climb. Trafficinfo and avoiding action was given to the A321. Standard separation maintained. This occurrence was the subject of a separate review by the UK AIRPROX Board - see AIRPROX Report no. 107/04. CAA Closure: No further CAA action required at this time.

200404180	23/06/2004	Lambourne (LAM)	UK AIRPROX 118/2004 - Between two B737s near the Lambourne Hold at FL90. Separation lost.	When the NE DEPS SC took over the sector, there was an a/c airborne from Luton on a DVR SID climbing to FL80. B737(A) was airborne from Stansted on a DVR SID also climbing to FL80. The SC's plan was to climb the Luton traffic above the LAM stack and appropriate co-ordination was carriedout. However, the SC annotated B737(A)'s fps in error. When clearing the a/c to climb he saw the co-ordination onB737(A)'s fps and climbed that a/c instead of the other a/c. This resulted in a confliction with B737(B) holding at LAM descending to FL90. STCA activated and one of the a/c reported a TCAS RA. Appropriate avoiding action taken by NE DEPS and Heathrow Approach. The incident will be subject to assessment by UKAB. CAA Closure: Appropriate ATC personnel action taken.
200406233	02/09/2004	Strumble (STU)	UK AIRPROX 166/2004 - B777 and an MD11 3nm NE of Strumbleat FL370. Both a/c received TCAS RAs.	Separation lost when B777 was cleared to climb to FL380 through the level of an MD11 at FL370. STCA activated. B777received and reacted to a TCAS RA. Traffic info given. The MD11 was eastbound at FL370 and had been cleared to route direct to Dover from just west of Strumble. The SC climbed two B777 aircraft, in stages, to FL380 whilst placing them on headings which ensured they stayed just to the north of the Upper ATS route centreline. The SC believed thatboth would be level at FL380 before lateral separation between these aircraft and the MD11 was eroded. This was notthe case and avoiding action was passed to all three aircraft. The first B777 filed an Airprox against the MD11 whilst the second B777 did not file, even though standard separation was not maintained. Appropriate local ATC action taken. CAA Closure: The hazard is adequately controlled bythe actions stated above. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200406625	15/09/2004	Lambourne (LAM)	UK AIRPROX 184/2004 - EMB145 and ATR42 at LAM. TCAS and SMF activated. ATC error.	The EMB145 and the ATR42 were in the LAM hold under the control of the LTCC LAM SC. The EMB145 was at FL140 and the ATR42 at FL150. Inexplicably, the Sector Controller cleared the ATR42 to descend to FL120, believing it was the next aircraft in the sequence. The pilot of the EMB145 immediately reported being below the ATR42 and action was taken by ATC to control the situation. TCAS also activated. Appropriate ATC personnel action taken. CAA Closure: The hazard is adequately controlled by the actions stated above.
200406808	20/09/2004	Aberdeen (ADN)	UK AIRPROX 174/2004 - AS332 and A320 at Aberdeen at 2500ft.	The AS332 was operating in the circuit SVFR at night. Itwas downwind left hand and instructed to report ready to commence its autorotation. Traffic information had been passed to the crew in respect of a departing aircraft, the subject A320. The departing A320 was given its airways clearance and cleared for take off. No traffic information waspassed nor any local restriction to its climb in respect of the AS332. The pilot of the AS332 reported carrying outa right hand orbit but, in actual fact, flew a racetrack pattern back towards the crosswind leg of the circuit. Dueto the relative positions of the two aircraft, the tower controller did not have them continuously visible. The A320 departed and, shortly afterwards, the pilot of the AS332advised that the departing aircraft had 'come quite close'. Appropriate local ATC action taken. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB). CAA Closure: The hazard is adequately controlled by the actions stated above.
200407028	29/09/2004	Ockham (OCK)	UK AIRPROX 183/2004 - Two A320 a/c at FL70, 6 nm East of Ockham. TCAS RA and STCA activated. Avoiding action and traffic info issued. ATC error.	A320(A) was inbound to Heathrow via BIG and descending toFL80. The controller instructed the crew to descend to FL70 and to leave BIG heading 275deg. Shortly afterwards, A320(B) came on frequency, descending to FL80 and inbound toOCK. The controller instructed the crew to make a right hand orbit on reaching OCK and leave on a heading of 075deg. Some 90 seconds later, the controller instructed A320(B)to descend to FL70. At that time, A320(B) was 4nm from OCK passing FL95 and A320(A) was on its heading of 275deg passing FL75. At 1507:05, the controller instructed the crewof A320(A) to turn right onto a downwind heading of 085deg. By now, A320(B) was 6nm north west of A320(A) and had commenced its right turn as instructed. The crew of A320(A)reported TCAS traffic 500 feet above, coming towards them. This transmission was simultaneous with the controller issuing instructions to the crew of A320(B) to stop their descent, having been alerted by a colleague. Separation lost as A320(A) responded to a TCAS RA descent and A320(B) stopped its descent before climbing back to FL80. Appropriate local ATC action taken. This occurrence is the subject of a separate review by the UK Airprox Board. CAA Closure:The hazard is adequately controlled by the actions statedabove.

200407727	22/10/2004	London-Heathrow - LHR	UK AIRPROX 197/2004 - A320 and a Canadair Regional Jet (CRJ) 25nm ESE of Heathrow at FL130.	During A320's cleared climb to FL130 it received a TCAS TA on descending CRJ above. A320 reduced its climb rate. ATC informed A320 that traffic had been cleared to descend to FL140 but CRJ descended through that level. The crew of the CRJ subsequently reported that they were inbound to BIG descending to FL140. On approaching FL140, the Captain realised that the First Officer (pilot flying) had selectedFL130. On realising his mistake, the First Officer immediately selected the altitude hold on the autopilot but the aircraft reached FL135 before levelling off. After reporting this altitude deviation to ATC, the CRJ then reported being cleared to descend to FL130. This occurrence is subject to a separate review by the UK Airprox Board. CAA Closure: No further CAA action required at this time.
200408170	09/11/2004	Lambourne (LAM)	UK AIRPROX 213/2004 - Between B737 and a B757 when ATC descended the higher a/c through the level of the lower a/c.Avoiding action given to both a/c. STCA and SMF activated.	Both aircraft were holding at LAM, under the control of TC Heathrow INT DIR N, whilst a runway change to westerly operations took place. The situation was complicated by a Northolt inbound through LAM at FL70 and the last two easterly departures routeing northbound. The B757 was holding at FL90, and the B737 was at FL100. In order to achieve maximum runway utilisation, the Director decided to sequence the B737 ahead of the B757. Both flights were instructed to leave LAM heading west. However, for an inexplicable reason, the Director transposed the levels of the two aircraft and cleared the higher B737 to descend. The B757 was 1.8nm ahead of the B737 when the descent clearance was issued. STCA activated and avoiding action turns were given to both aircraft. Appropriate ATC personnel action taken. A separate review will be carried out by the UK AIRPROX Board under AIRPROX 213/2004. CAA Closure: The hazard is adequately controlled by the actions stated above.
200408349	17/11/2004	Edinburgh (EDI)	UK AIRPROX 212/2004 - B757 and a BAe146 22nms ENE of Edinburgh at 4,400ft.	Both a/c were being vectored for runway 24 by Edinburgh Approach, staffed by a mentor and an experienced trainee.The B757 was positioned in the sequence ahead of the BAe146. The trainee vectored the B757 outside CAS on its downwind leg, due to a number of a/c ahead. The B757 was cleared to descend to 3000ft and the BAe146 to 4000ft. When the trainee placed the former on a closing heading for the ILS, he misread the a/c's Mode C, believing it to have vacated 4000ft. Consequently, this turn resulting in it conflicting with the BAe146, on a downwind heading. The BAe146 was given a right turn away from the B757. CAA Closure: Appropriate ATC personnel action taken. This AIRPROX will be subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200405390	05/08/2004	Goodwood (GWC)	UK AIRPROX 144/2004 - A320 and A340 at FL130 in vicinity of Goodwood (GWC). A320 received TCAS TA and was issued avoiding action by ATC. A320 unaware of A340, which was on adifferent frequency.	The A340 was routeing eastbound heading 070deg and descending to FL130 working the S20 Tactical. The A320 was initially northbound descending to FL160 and working the S19 Tactical. Previous co-ordination had been for both aircraftto be heading 045deg descending to FL130 and transferred to TC, but this was amended to heading 070deg. The S19 Tactical did not register the revised heading and turned the A320 right onto 045deg and descended it to FL130. The two aircraft, one working the S20 Tactical and the other the TC OCK SC, came into confliction. Appropriate local ATC action taken. CAA Closure: The hazard is adequately controlled by the actions stated above.
200405607	15/08/2004	Lambourne (LAM)	UK AIRPROX 148/2004 - BD700 and A320 6nm East of LAM at FL80. ATC error.	The A320 was inbound to Heathrow via Lambourne. It was required to carry out one hold before being vectored to theILS. As it was completing this hold the Director descended it to FL80. This was the Minimum Stack Level which hadbeen delegated to the NE Departures controller. As the A320 descended to FL80 it came into conflict with an outbound BD700 which was climbing to FL80. Appropriate local ATC action taken. CAA Closure: This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB). No further CAA action required.
200501849	16/03/2005	Belfast (BEL)	UK AIRPROX 31/2005 - A321 and military helicopter at 3000ft as A321 departed Belfast City. A321 received TCAS TA.	The A321 was given take-off clearance to 3000ft straight ahead from runway 22, and was advised of helicopter traffic to the right in the climb, not above 3000ft VFR. On transfer to Aldergrove, the A321 was instructed to climb to FL90. The A321 pilot responded that there was traffic shown on his TCAS, 2.5nm ahead and 200ft above. The controller confirmed that there was traffic at 3000ft at 2nm, but the A321 pilot believed that the traffic would be north of thecentreline. The A321 expedited their climb to FL90. He never sighted the military helicopter, which appeared to have a malfunctioning transponder at the time. This occurrence is the subject of a separate review by the UK Airprox Board. CAA Closure: No further CAA action required at this time.

200502932	20/04/2005	Teesside (TD)	UK AIRPROX 53/2005 - B757 and military a/c at FL190, 18nmWest of Teesside. B757 received a TCAS RA. Avoiding action issued. Separation lost.	The military controller co-ordinated a crossing of the TILNI RC for a military jet at FL190. The B757, southbound from Newcastle, was cleared to FL180, underneath the Tornado, by the MACC N/E Radar Controller. Subsequently, anotherflight, fltnum 1DF was cleared to climb to FL250. However, the pilot of the B757 (fltnum 13F), different company, responded to the message. This was undetected by the controller. The pilot of 1DF warned that another aircraft had replied. The controller checked with another company aircraft but did not pursue the matter further. He was alerted tothe situation by STCA activation. He issued an 'avoiding action' turn whereupon the pilot responded receiving a TCAS RA. Standard separation was lost. Appropriate ATC personnel action taken. □ CAA Closure: The hazard is adequately controlled by the actions stated above.
200503015	26/04/2005	Teesside (TD)	UK AIRPROX 55/2005 - A320 and military jet, 10nm SW of Teesside at 3500ft.	A320 inbound on the ILS had been identified to military ATC and a course of action was agreed. Military ATC then allegedly positioned military jet in conflict with A320. Avoiding action given to A320 who received/complied with a TCAS RA. The UKAB review of this AIRPROX concluded that the cause was that in a high workload situation for the military controller and following a misunderstanding by the Durham Tees Valley Approach controller, neither controller achieved the separation required under a RAS. □ CAA Closure: No further CAA action required. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200503999	28/05/2005	Bovingdon (BNN)	UK AIRPROX 78/2005 - EMB145 and B777 in the Bovingdon Hold at FL80.	Traffic info and avoiding action was given. EMB145 reported receiving a TCAS RA. STCA and SMF activated. Investigation established that controller incorrectly believed that minimum stack level (MSL) was FL80 and, following B777 departure, climbed B777 to FL80 in error. B777 then lost separation with EMB145 which was descending to FL80 in the BNNHold. Controller would have received both verbal and visual notification of MSL. Appropriate ATC personnel action taken. This occurrence is the subject of a separate review by the UK Airprox Board.□ CAA Closure: The hazard is adequately controlled by the actions stated above.
200506574	15/08/2005	Ockham (OCK)	UK AIRPROX 138/2005 - A321 and B737 at FL80 4nm East of OCK. B737 issued a climb clearance through the level of theA321. B737 and A321 received and actioned TCAS RAs.	Traffic info and avoiding action given. Investigation established that controller was working with a trainee who was getting behind with the traffic situation, which prompted the controller to take over. On doing so, controller instructed B737 to climb to FL120, which placed the a/c into confliction with the A321 and resulted in the loss of separation. Appropriate local ATC action taken.□ CAA Closure: The hazard is adequately controlled by the actions stated above. This AIRPROX will be subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200507389	06/09/2005	London-Heathrow - LHR	UK AIRPROX 164/2005 - A320 and a Extra 300 11nm West of Heathrow at 3300ft.	Information indicates that the Extra a/c, which was carrying out aerobatics, stayed below CAS whilst carrying out its manoeuvres. See also 200504548.□ CAA Closure; No further CAA action required. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200508163	03/10/2005	Brookmans Park (BPK)	UK AIRPROX 190/2005 - A321 and an A320 at CHT at FL80. Loss of separation. A320 received a TCAS RA. STCA and SMF activated.	Investigation ascertained that the departing A320 was issued a climb from 6000ft to FL110, which placed it into conflict with the A321 (being vectored by another controller). Both controllers passed traffic info and avoiding actionbut separation was lost. Appropriate local ATC action taken.□ CAA Closure: The hazard is adequately controlled by the actions stated above. This AIRPROX will be subject to aseparate review by the United Kingdom AIRPROX Board (UKAB).
200700285	12/01/2007	Biggin (BIG)	UK AIRPROX 11/2007 - A319, climbing to FL140, reported a TCAS RA against an A340 descending to FL150, which also received an RA. STCA activated. Standard separation maintained. STCA	CAA Closure: Investigations indicate that the A319 was climbing at a rate of 4000fpm and this triggered the TCAS RAs. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200705666	22/06/2007	Biggin (BIG)	UK AIRPROX 90/2007 - Loss of separation between an MD82 and an A320 in the Biggin hold. MD82 had an autopilot failure or the system was mishandled.	The MD82 descended below its cleared FL110. Avoiding action given.□ CAA Closure: No further CAA action. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200706800	21/07/2007	Compton (CPT)	UK AIRPROX 105/2007 - A320 and a Skyvan, 19nm Southwest of CPT VOR at FL140.	As A320 was passing FL150 during descent to FL140, a paradropping squawk was observed just outside CAS on a conflicting heading at FL130 and climbing. A320 was given traffic info and a left turn. A320 reported a/c on TCAS. Unknowna/c continued climb and touched the Southern edge of the Airway. A320's descent was stopped and avoiding action wasgiven. STCA activated.□ CAA Closure: No further CAA action required. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB).

200707766	15/08/2007	London City - LCY	UK AIRPROX 118/2007 - B767 and an RJ100 4nm Northwest of London City at 3500ft.	B767 cleared in descent on QNH 996mb. Pilot subsequently advised ATC that the QNH was set to 1013mb. B767 climbed back to 4000ft on the correct QNH setting. The RJ100 reported a TCAS RA. CAA Closure: No further CAA action. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200709147	27/08/2007	London-Heathrow - LHR	UK AIRPROX 139/2007 - B737 and a balloon at 3000ft on approach to 27L.	Conflict with an untraced special shape balloon with a line underneath it, in Class A airspace. CAA Closure: No further CAA action required. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200704668	29/05/2007	PENIL	UK AIRPROX 62/2007 - A320 and A319, 20nm Southeast of PENIL at FL380. STCA activated. A319 received a TCAS TA.	The A320 was cruising at FL380 and had been coordinated with the Daventry (South) Sector to make a direct routeing which would just cut the corner of their airspace. It was decided that the A320 would not be transferred to the Daventry (South) Sector frequency. The Tactical and Planner were both aware of the a/c, but neither produced a strip forthe data display. A handover of the Daventry (South) Tactical position then took place, with a mentor and trainee occupying the position. During this handover, no mention was made of the A320. The A320 was then transferred from theDaventry (North) frequency to the Lake frequency where, at the time, the A319 was on frequency. Shortly afterwards,the A319 crew were instructed to contact the Daventry (South) Sector. In accordance with the standing agreement, the Daventry (South) trainee instructed the A319 crew to descend from FL390 to FL200 to be level by TOBID. Neither thetrainee or the mentor noticed the A320, which was trafficto the A319 and clearly displayed on the radar. Soon afterwards, the conflict was detected and the trainee instructed the A319 crew to expedite their descent. The mentor took over the position and issued avoiding action. Meanwhile,the Lakes controller, who was controlling the A320, issued an avoiding action turn to the crew, but separation was lost. Appropriate local ATC action taken.
200810828	05/10/2008	Detling (DET)	UK AIRPROX 138/2008 - B777 and B757 at Detling at FL190.	B777 called on frequency climbing to FL170 on radar heading 095deg and was cleared to continue on heading and climbto FL290. A B757 approximately 6nm South of B777, called on frequency also climbing to FL170 on heading 095deg and was cleared to climb to FL280. A short time later B777 wasobserved on heading 110deg and converging with B757. STCAactivated. Traffic info and avoiding action was given to both a/c. Separation was lost. CAA Closure: The B777 crewdeviated from their assigned heading and turned into conflict with the B757. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200811377	15/10/2008	Lambourne (LAM)	UK AIRPROX 148/2008 - Two military a/c squawking 7600 andan A321, 20nm Northeast of the Lambourne hold at FL170. Other a/c in the area were given vectors away from the military a/c.	Although standard separation was maintained between the military a/c and the A321 subject to this AIRPROX, two losses of separation occurred as a result of the infringementsof CAS by the military jets, once against an MD90 and also against an A319. CAA Closure: Investigations indicate that the military formation did not comply with exercise recovery procedures as specified and entered CAS without a clearance. A UKAB recommendation was raised as a result of this AIRPROX.
200801262	11/02/2008	London-Heathrow - LHR	UK AIRPROX 16/2008 - Enstrom 480 and an A321 overhead Heathrow. Enstrom did not follow airfield crossing procedure.Traffic info given.	See also 200611449. CAA Closure: The pilot misheard theonward clearance from Bedfont. The controller misheard the readback and did not detect the absence of the routeing instruction. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200800059	05/01/2008	Bovingdon (BNN)	UK AIRPROX 15/2008 - Separation lost between an A321 in the BNN Hold at FL130 and a B737 outbound from Stansted. ATC error. STCA activated. TCAS RAs received by both a/c.	Investigation ascertained that the plan was to turn the B737 to route over the BNN hold, thus avoiding traffic at FL130 to the West of the hold at CPT, and to climb to FL160before transfer to the next sector. The controller took over the position just after the B737 had been instructed to climb to FL130. He instructed the crew to turn left heading 220deg, but omitted to issue a climb clearance. The B737 then came into conflict with the A321 and TCAS resolvedthe confliction. CAA Closure: Appropriate local ATC action taken. This AIRPROX will be subject to a separate review by the United Kingdom AIRPROX board (UKAB).
200801540	14/02/2008	LORKU	UK AIRPROX 20/2008 - A321 and military a/c, North of LORKU at FL310. Loss of standard separation.	TCAS, SMF and STCA activated between an A321 on a headingpassing FL300 during climb to FL330 and a military a/c operating in the E3 orbit area at FL300 descending. The A321pilot contacted the S20 Tactical controller and was instructed to climb, in stages, to FL330. During this time the FOST area became active and the E3 was operating at FL310.As the A321 had already been coordinated out of the sector at FL330, the Tactical believed that he would still be able to achieve this and so permitted the crew to continue their climb. The A321 was transferred on passing FL290 andthen the Tactical determined that the two aircraft could still possibly conflict. A call was made to Brest but confusion existed, not least caused by the fact that Brest do not have military tracks displayed on their radar nor did they know that the FOST area was active. Separation lost. CAA Closure: Appropriate local ATC action taken. This AIRPROX will be the subject of a separate review by the UK Airprox Board (UKAB).

200803967	24/04/2008	Lambourne (LAM)	UK AIRPROX 49/2008 - Separation lost between a B767(1) climbing to FL240 that was stopped at FL130 and a B767(2) descending to FL120. Avoiding action given. TCAS activated.	ATC noticed a potential conflict between a B767(1) climbing to FL240 and a B767(2) descending to FL120. ATC told B767(1) to stop climb at FL130 with the intention to stop B767(2) at FL140, but controller was then interrupted by another a/c and B767(2) continued its descent to FL120. Avoiding action was given, although the words "avoiding action"were not used, and separation was lost.□ CAA Closure: Appropriate local ATC action taken. This AIRPROX will be subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200803998	26/04/2008	Lambourne (LAM)	UK AIRPROX 50/2008 - Two A319s 5nm West of Lambourne at FL80.	During high workload ATC cleared an A319(1) in the LAM Hold to descend from FL90 to FL80 in error and separation was lost with another A319(2) at FL80. STCA and SMF activated.□ CAA Closure: Appropriate ATC personnel action taken. This AIRPROX will be subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200805928	06/06/2008	Biggin (BIG)	UK AIRPROX 77/2008 - Two A319 a/c at FL90. Avoiding action given.	The avoiding action was passed once controller realised that the plan was not going to work. No traffic info issued. Only one a/c received avoiding action as the controller erroneously believed that the other had been transferred to Approach.□ CAA Closure: Appropriate ATC personnel actiontaken. This AIRPROX will be subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200601694	04/03/2006	London-Heathrow - LHR	UK AIRPROX 26/2006 - A319 and an A320, 4nm South of Heathrow at 2000ft.	A319, at 2000ft during a standard missed approach called for by ATC, observed an A320 in the one o'clock position, crossing ahead at the same altitude. Other a/c was also ona missed approach. ATC instructed A319 to turn onto a heading. Investigation ascertained that the A320 had been sent around due to possible debris on the runway and the A319also carried out a missed approach. Both flights were on standard missed approaches but the A320 turned slightly late on the route and was flying slower than the A319 and soseparation was lost. The controller concerned did not ensure that separation between the two a/c was maintained. Appropriate ATC personnel action taken.□ CAA Closure: The hazard is adequately controlled by the actions stated above. This AIRPROX will be subject to a separate review by theUnited Kingdom AIRPROX Board (UKAB).
200603113	17/04/2006	London City - LCY	UK AIRPROX 46/2006 - C560 climbed above its cleared altitude of 3000ft whilst on a DVR 3T SID and lost separation with an LJ60 at 4000ft. Traffic info was given.	LJ60 received and reacted to a TCAS RA. The C560 pilot climbing out of London City with a high ROC became distracted and allowed the a/c to exceed its cleared altitude. The pilot concerned has received special training to avoid a recurrence of this kind of incident.□ CAA Closure: No further CAA action required. This AIRPROX has been subject to aseparate review by the United Kingdom AIRPROX Board (UKAB). UKAB Report 046/06 refers.
200605785	04/07/2006	Durham Tees Valley (TD)	UK AIRPROX 89/2006 - EMB145 and a military jet 12nm SW ofTeesside in Class G airspace. EMB145 received a TCAS RA.	The military jet pilot flew sufficiently close to the EMB145 to cause a TCAS RA. Contributory factors were that theDurham Tees Valley controller did not provide avoiding action to the EMB145 IAW the MATS Part 1 and the Leeming Zone controller did not provide traffic info to Durham Tees Valley in accordance with the LoA.□ CAA Closure: No furtherCAA action required. This AIRPROX has been subject to a review by the United Kingdom AIRPROX Board (UKAB). See UKABReport 089/06.
200609741	27/10/2006	Bournemouth	UK AIRPROX 157/2006 - Falcon 900 and a PA34 at 3000ft, 1.5nm West of Bournemouth. Falcon 900 instructed to climb to2000ft, a/c observed at 3000ft. Avoiding action given.	The Falcon 900 had taxied for departure, lined up on R/W 26 and was issued with an Airways clearance. This was readback correctly to maintain FL70. The Bournemouth APS controller subsequently released the a/c with the restriction to maintain heading 270deg and climb to 2000ft (altitude).This was passed to the a/c by the ADC and was acknowledged by the pilot. This procedure followed the approved unit procedures for the issuing of an Airways clearance and thesubsequent IFR release. In accordance with unit procedures, once airborne and prior to transfer to the APS, the ADCconfirmed with the a/c to maintain 2000ft on reaching. The Falcon initially asked if that transmission was for him.ADC confirmed it was and repeated the transmission, whichwas eventually read back. The height readout of the a/c was then noted as 3000ft and it was instructed to descend to 2000ft immediately. The a/c questioned that he was beingasked to maintain 2000ft, stating that he had been cleared to 7000ft. The level bust resulted in an AIRPROX with a PA34 in the hold at 3000ft, which was given prompt avoiding action by the APS Controller as soon as it was noted that the departing a/c had climbed through its cleared level.The controller's RT phraseology contributed to this AIRPROX.
200611392	16/12/2006	Daventry (DTY)	UK AIRPROX 178/2006 - Separation lost when ATC cleared a B737 to climb to FL190, through the level of a B757 at FL180. B737 reported	CAA Closure: Appropriate local ATC action taken. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200903014	01/04/2009	ERING	UK AIRPROX 2009/020 - A321 and two military jets 24nm Southeast of Clacton at FL150.	Following coordination between civil and military ATC, separation was lost between a pair of descending military jets and a descending A321. STCA and SMF activated. □ CAA Closure: The military controller descended the military jetsinto conflict with A321. This AIRPROX has been subject toa separate review by the United Kingdom AIRPROX Board (UKAB).

200907804	27/07/2009	London City - LCY	UK Serious Incident and UK AIRPROX 2009/079 - B777 and C525, 3nm Northwest of London City at 4000ft. AAIB Field investigation.	CAA Closure: The crew of the C525 were cleared to depart London City Airport on a DVR 4T SID, which required them to climb initially to 3000ft. They read back their cleared altitude as 4000ft, an error that was not noticed by the Tower controller. At about the same time, the B777 was cleared to descend to an altitude of 4000ft while turning ontoa southerly heading prior to intercepting the ILS for R/W27R at Heathrow Airport. The C525 climbed through 3000ft while turning right and passed the B777 on a nearly reciprocal heading. The B777 generated three TCAS RAs in short succession but the a/c did not follow the commands. The C525was unable to generate RAs. The crew of the C525 saw the B777 in time to take effective avoiding action. Five Safety Recommendations are made, nr 2010-056 addressed to National Air Traffic Services, nrs 2010-057 and 2010-058 addressed to London City Airport, nr 2010-059 addressed to the Directorate General of Civil Aviation of Turkey and nr 2010-060 addressed to the Civil Aviation Authority. AAIB Bulletin 09/2010, Ref: EW/C2009/07/07. UKAB are continuing withtheir review of this incident.
200912480	19/11/2009	London-Heathrow - LHR	UK AIRPROX 2009/146 - A320 and B737 at Heathrow at 4600ft.	A320 took off on a CPT SID and was climbing well, but with a relatively low forward speed. The next departure, a B737 on a DVR SID, began to catch A320 and was instructed tostop at 4000ft. B737 reported that it was already passing4000ft and would descend. STCA and SMF activated. Trafficinfo and avoiding action was given to A320. The Heathrow departure R/W was being operated by a mentor and trainee. The A320, on a CPT 3F SID, departed ahead of the B737, on a DVR 5F SID. The time interval required between them was one minute, however, the B737 departed 43 seconds behind the A320. The a/c should have been placed on appropriate headings before being transferred to LTCC but the trainee transferred the A320 before this occurred. The A320 was given an avoiding action turn on first contact with LTCC. CAAClosure: Appropriate ATC personnel action taken. Additionally, Safety Notice 02/10 "Aircraft Departure Performance"has been published to alert controllers. This AIRPROX is subject to a separate review by the United Kingdom AIRPROXBoard (UKAB).
201100058	04/01/2011	London-Heathrow - LHR	UK AIRPROX 2011/001 - A319 and a Bell 206 at Heathrow.	Bell 206, carrying out pipeline inspection, cleared to cross R/W27L and remain South of R/W27R. After completing inspection, Bell 206 turned 180deg and was reported close toA319 departing R/W27R. The crew of the A319 had previously been advised by ATC of the helicopter's position but, observing the helicopter on a converging course, they becameconcerned as to the possibility of reduced separation between the two a/c and were prepared to react if necessary. However, the helicopter was then observed to turn away from them and so no avoiding action was necessary. CAA Closure: It has been recommended that ATC procedures are amended to ensure that the Heathrow Tower Supervisor is involvedin the approval process for survey flights before the flight gets airborne when the detail involves activity within4nm of Heathrow. This AIRPROX will be subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
201100969	01/02/2011	Lambourne (LAM)	UK AIRPROX 2011/007 - EMB170 and an A319, 10nm Northeast of the LAM hold. Avoiding action issued. STCA activated. Both a/c received/complied with their respective TCAS RAs. Separation lost.	The AIRPROX occurred on the LTC NE Sector, 10nm NE of LAMat FL080 when the NE controller turned an A319 into confliction with an EMB170. The A319 was at FL080 and had been instructed to resume its own navigation to LAM. The EMB170was climbing to FL090 on a heading of 050deg. An analysisof the incident determined that the controller, having experienced a tunnelling of the information displayed to him, had failed to integrate the position of the EMB170 into his decision to turn the A319 towards LAM. The controller experienced a complex workload comprising of non-standard flights, non-standard a/c routings, a request to join controlled airspace from an unanticipated Elstree departure and operational pressures to release a/c from Luton. The issues concerning the Elstree departure have been addressed by LTC and Elstree: namely, unit personnel have been reminded of the correct procedures for departures and the AIP has been updated to advise pilots that they are to call LTC GW Approach on departure. CAA Closure: No further CAA action at this time. This AIRPROX will be subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
201003527	25/04/2010	Lambourne (LAM)	UK AIRPROX 2010/034 - MD82 and unknown, 5nm East of LAM at FL170.	Prior to entering the LAM hold, MD82 at FL170 reported seeing an object that looked like a parachute/hang glider. Nothing was observed by other traffic in the area. CAA Closure: Conflict in Class A airspace with an untraced a/c. No further CAA action possible. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB).

201004833	28/05/2010	Biggin (BIG)	UK AIRPROX 2010/073 - Two A321s near BIG Hold at FL115.	A321(1) descending to FL80 came onto frequency and was instructed to leave BIG heading 270deg. It became apparent that A321(1) had taken the heading straight away, which putit into conflict with an outbound climbing A321(2). A321(1) was given avoiding action. STCA activated and A321(2) reported receiving a TCAS RA. Investigation established that the pilot of A321(1) incorrectly read back the heading instruction and the controller missed the incorrect readback. Neither controller used appropriate avoiding action phraseology and neither pilot reported that they were responding to a TCAS RA. CAA Closure: This AIRPROX will be subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
200600177	10/01/2006	Lambourne (LAM)	UK AIRPROX 2/2006 - FK100, an A320 and a B737 East of LAMat FL170. The FK100 appears to have left its assigned radar heading. Separation lost. STCA/SMF/TCAS RA.	A320 received and reacted to a TCAS RA. The FK100 crew allowed their a/c to deviate from its assigned heading in Class A Airspace, bringing into conflict with both the B737 and A320. CAA Closure: The operator of the FK100 has been fully alerted to the UKAB findings with regard to this AIRPROX. No further CAA action required. See also UKAB Report 2/06.
200600694	27/01/2006	Ockham (OCK)	UK AIRPROX 12/2006 - Poor phraseology used during co-ordination resulted in a separation loss between an A321 and aclimbing B737. STCA and SMF activated. Traffic info and avoiding action given.	Investigation established that the B737 contacted the LTCC SW Deps/OCK controller at 4000ft, having departed Gatwick on a KENET SID. Meanwhile, outbound from Heathrow, were two a/c on MID SIDs (the second of which was the A321), operating for the same company and working the LTCC Willo controller. The SW Deps/OCK controller requested a higher level for the B737 against the first of these two a/c and had not observed the second flight. The Willo controller agreed to the co-ordination, believing it was against the second a/c (the A321). During the co-ordination, the controllers did not utilise the full callsign of the a/c involved as they are required to do and the B737 was cleared to climb to FL130, into confliction with the A321. Once the situation was recognised, turns and respective climb/descent clearances were issued to both flights but separation was lost. Appropriate ATC personnel action taken. CAA Closure:The hazard is adequately controlled by the actions statedabove. This AIRPROX will be subject to a separate review by UKAB.
201207467	03/07/2012	Glasgow	UK AIRPROX 2012/094 - A319 and SB2000 at FL180. Traffic info and avoiding action given. TCAS, STCA and SMF activated. Separation lost.	A319 received and complied with TCAS RA 'climb', and SB2000 received and responded to TCAS RA 'descend'. Investigation established that the AIRPROX occurred when the controller climbed the A319 through the level of the SB2000 without ensuring that standard separation would be maintained. The controller failed to monitor and observe pertinent information. In this instance, the information was available but the controller failed to include it in their scan pattern due to the focus of their attention being on the completion of a previous task. CAA Closure: Appropriate unit action taken after the incident. This AIRPROX will be subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
201002694	10/03/2010	London-Heathrow - LHR	As B737 was passing 2800ft during descent to 2500ft it received a TCAS TA. No conflicting a/c could be identified from radar recordings. B737 initially filed an AIRPROX which it subsequently	
201204093	17/04/2012	Lambourne	UK AIRPROX 2012/050 - A340 and an A320 at FL80, 13nm West of Lambourne. Traffic info and avoiding action given. Separation lost. STCA and SMF activated. TCAS TA.	Information indicates that this AIRPROX was caused by A340 crew deviating from their assigned heading and turning into conflict with the A320. Investigations indicate that this AIRPROX stemmed from a CRM issue on the A340 flight deck. Although the crew reported high workload owing to thunderstorm activity, the crew needed to prioritise their tasks to ensure SOPs were carried out normally as well as the extraneous tasks. When the LTC NE controller issued a continue present heading climb now flight level one five zero instruction, the FO read it back correctly but did not monitor the actions of the PF. The FO monitored the PF selecting an open climb on the FMS but did not notice the PF change from Nav to Hdg mode and then select 150deg. As a result, the A340 deviated from its assigned heading and turned into conflict with the A320, causing the AIRPROX. The root cause of this AIRPROX was thus: increased flight deck workload due to thunderstorm activity in the area. The pilot of the A340 believing the ac had been cleared on to heading 150deg at the same time as being cleared FL150. This belief was likely pre-disposed by the increased flight-deck workload on the A340. CAA Closure: As a result of this AIRPROX, the operator has reviewed the different procedures used by different airlines
201207660	08/07/2012	TIGER	UK AIRPROX 2012/099 - Loss of separation between an A319 and an A321. STCA activated. A319 received TCAS TA. Traffic info and avoiding action given.	The prevailing weather conditions resulted in a number of a/c requesting weather avoidance and changes to stack holding procedures. The complexity of the LTC BIG controller's workload caused the controller to become agitated and distracted, focusing on a plan to climb an outbound A319 through the level of a B737 holding at Detling (DET) at FL130. The controller forgot about the A321 at FL150 and cleared the A319 to climb to FL170 bringing it into conflict with the A321. CAA Closure: The controller realised the error and gave avoiding action and traffic info to the A321. The A321 became visual with the A319. In consultation with the CAA, appropriate ATC unit action has been taken. This AIRPROX will be subject to a separate review by the United Kingdom AIRPROX Board (UKAB).

201206049	02/06/2012	Ockham (OCK)	UK AIRPROX 2012/075 - B777 and an A320.	Separation lost. Traffic info and avoiding action given. STCA and SMF activated. B777 at FL120 had taken a call intended for B747 to descend to FL80. Investigations indicate that there were two a/c, of the same operator, on the same frequency, for a long while, 98 and 94. The pilot of 98 realised almost immediately that he had read back a clearance for 94. The a/c had descended to within 500 feet of an A320, and a TA was received. An RA was never received, and separation was regained. CAA Closure: No further CAA action. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
201214539	02/12/2012	EGPF (GLA): Glasgow	UK AIRPROX 2012/166 - A320 and an unknown a/c (believed to be a microlight or similar) at 3500ft on approach to Glasgow. Nothing	CAA Closure: After further analysis confirmation has been received that no conflicting traffic was on frequency or showing on Glasgow or Lowther Hill radars. Attempts to identify the a/c were unsuccessful. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
201309043	22/07/2013	Daventry	UK AIRPROX 2013/085 - A320 in Class C airspace and a DHC8 descending into Class A airspace, 4nm Northwest of Daventry. A320 received/complied with TCAS RA to climb. DHC8 also received/complied with a TCAS RA. Traffic	CAA Closure: Appropriate action taken to resolve potential conflict. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB). AIRPROX Board (UKAB) information indicates that this AIRPROX was due to the TC Welin controller allowing the DHC8 to come into conflict with the A320.
201301076	02/02/2013	BCN	UK AIRPROX 2013/005 - Loss of separation between an A319 and an A320, 5nm North of DIKAS. STCA and SMF activated. Traffic info and avoiding action given.	The LAC Local Area Group West (LAG (W) were operating as London Control in band-boxed mode with all sectors combined. The A319 was westbound at FL340 and the A320 northbound at FL360. The Tactical controller instructed the A320 to descend to FL350 with no response. The Tactical controller gave a second instruction for the A320 to descend to FL350. However the nature and quality of the A320's incorrect readback, not unreasonably, caused the Tactical controller to accept it as being correct (FL350). The Tactical controller did not notice that the A320's Selected Flight Level was indicating FL250. When STCA activated the Tactical controller was convinced that it was spurious and that the A320 would level off at FL350 with vertical separation assured. As a result the Tactical controller did not monitor the two a/c labels or observe the Mode C readout of the A320 as it descended through FL350. The Planner controller was engaged in coordination tasks and was not aware of the situation. The Tactical controller did not notice the deviation/interaction alerts generated by iFACTS at the crucial point, when the A320 continued its descent into conflict with the A319. It was determined that the two instructions transmitted by the Tactical controller to the A320 giving a descent clearance to FL350 were clearly distinguishable and the readback from the A320 pilot could easily have been
201307348	23/06/2013	FINDO	UK AIRPROX 2013/054 - Loss of separation between two B747s at FL340. STCA activated. Both aircraft received a TCAS RA. Traffic info and avoiding action issued.	ATC instructed one of the B747 to climb to FL340, a level already occupied by the other which was on a conflicting track. The confliction was detected by STCA in sufficient time for the controller to pass avoiding action, which was given. According to the simulation subsequently conducted, the avoiding action issued would have ensured that separation was maintained if each aircraft had followed it correctly. However, despite reading back the headings given by ATC correctly, the crew of each aircraft believed that they had been instructed to turn onto the heading that had, in fact, been issued to the other. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB). AIRPROX Board (UKAB) information indicates that this AIRPROX was due to the pilots of aircraft on converging tracks flying into conflict because, although they had acknowledged timely avoiding action, they did not follow it.
201311399	08/09/2013	EGLC (LCY): London city	UK AIRPROX 2013/144 - EMB190 and an unidentified object near London City, in Class A airspace. EMB190 pilot believed the object to be	Radar recordings could not definitively determine the presence of another aircraft in the vicinity. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB). AIRPROX Board (UKAB) information indicates that this AIRPROX was a sighting report.
201314226	05/11/2013	BNN	UK AIRPROX 2013/156 - B747 in the BNN hold at FL90 and a B767. Traffic info and avoiding action given. STCA activated.	B767 cleared climb FL80 but observed indicating FL86. Aircraft reached FL86 prior to descending to correct flight level having selected correct pressure setting. CAA Closure: The prompt action taken ATC prevented a loss of separation. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB). AIRPROX Board (UKAB) information indicates that by not selecting the Standard Altimeter Setting in time the B767 pilot climbed above his cleared level and into conflict with the B747.
201311208	03/09/2013	HAZEL	UK AIRPROX 2013/132 - Two A321 aircraft. Avoiding action given.	ATC instructed A321(1), passing FL122 in climb to cleared FL150, to immediately descend to FL120. Reporter commented that A321(2) was told to stop descent at FL140. A321(1) reached FL125 before descending, standard separation maintained. CAA Closure: This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB). AIRPROX Board (UKAB) information indicates that this AIRPROX was due to the controller incorrectly instructing the A320(1) pilot to climb; the conflict was resolved by the controller before separation minima were eroded.

201307391	23/06/2013	DVR	UK AIRPROX 2013/091 - A330 and an unidentified object in Class C airspace.	CAA Closure: AIRPROX Board (UKAB) information indicates that this AIRPROX was a sighting report. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB). Lebanese CAA advised.
201315024	21/11/2013	LON	UK AIRPROX 2013/161 - B747 and a C750. Traffic info and avoiding action given.	Supplementary 28/02/14: The reported Airprox was caused when the C750 crossed south of the offset centreline for runway 07 at Northolt and came into confliction with the B747 on final approach for Heathrow. The Northolt approach controller had been unable to vector the C750 more expeditiously because the aircraft had not been transferred by LL INT N. CAA Closure: The AIRPROX was reported following the issuance of avoiding action to the B747 on final approach to London Heathrow's runway 09L. Separation minima were effectively maintained. The LL FIN controllers (trainee and mentor) were alert to the prevailing strong northeasterly wind and reacted promptly when the C750 flew through the extended offset centreline for Northolt's runway 07. Whilst LL INT N transferred the C750 in accordance with ATC requirements and as notified to pilots in the AIP; the prevailing wind, its effect on the C750's ground speed and the apparent time taken for the C750 to turn - hindered Northolt Approach's ability to vector the C750 without it passing south of the extended centreline and into potential proximity with the B747. No further action necessary. This AIRPROX will be