

Follow-up Action on Occurrence Report

ACCIDENT TO SLINGSBY T67B FIREFLY, G-BLTV, NEAR BANBURY ON 3 NOVEMBER 2002 (AIRCRAFT SPUN INTO GROUND DURING SPINNING TRAINING EXERCISE)

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SYNOPSIS

(From AAIB Report)

On the day of the accident, both pilots had other flights prior to the accident flight. They flew one training flight together in a PA-28 and each flew a training flight in a PA-28 with other pilots. These pilots considered that the two pilots involved in the accident appeared well and, during the morning, a further pilot saw the two accident pilots briefing for a forthcoming flight.

Prior to the accident flight, G-BLTV had been flown twice by other pilots. The first flight of the morning involved some aerobatic manoeuvres, including a loop and an aileron roll, and the pilots who flew the aircraft confirmed that it appeared fully serviceable. One of these pilots recalled that the control column appeared slightly stiff when he moved it rearwards during checks prior to flight. However, he was able to achieve full control movement and subsequently noted no airborne unserviceabilities. Discussions with these pilots revealed that the aircraft had approximately 4 gall imp of fuel indicated on the gauges just prior to the accident flight and that the flight instruments and stall warning device worked as normal. The only known loose articles in the cockpit were a small fuel strainer under the left seat and a paper checklist under the right seat.

The weather was good with a surface wind of 210°/10 to 15 kt, visibility of 10 km, rain showers and scattered cloud at 1,500 feet and 2,500 feet amsl. In accordance with normal practice, a 'Departure Authorisation Form' was completed. This indicated that the flight would depart with the two pilots involved in the accident at 1315 hrs for a duration of 45 minutes.

A recording of the Oxford 'Tower' radio traffic on frequency 133.425 MHz, included transmissions relating to G-BLTV. The crew called the tower at 1306 hrs for clearance to taxi to the fuel pumps. A subsequent check indicated that 57.32 litres (12.6 gall imp) of fuel was uploaded; this would result in approximately 16.6 gall imp of fuel in the aircraft. Then, at 1319 hrs the crew called for taxi clearance and subsequently reported ready for departure at 1326 hrs. At 1328 hrs, G-BLTV was cleared for takeoff on Runway 19. After departure, at 1332 hrs, the crew reported that the aircraft was leaving the 'Zone' and requested a Flight Information Service; ATC replied with a confirmation of that service and no subsequent transmissions were heard from G-BLTV.

There were only a few witnesses to the manoeuvres of the aircraft during the flight. One witness was standing with her partner about 1.5 km south of the accident site. She described the visibility as excellent and the weather as bright and sunny with a few scattered clouds. She heard the sound of a small aircraft and looked up to see it in the direction of Banbury and apparently flying towards her. The wings were level and the engine was "steady". As she

This publication provides the initial CAA response to each Safety Recommendation made by the Air Accidents Investigation Branch, Department of Transport. **Status 'CLOSED' or 'OPEN' indicates completion or not of all actions judged appropriate by the CAA in response to the Recommendation.**

The current status and the final responses to all Safety Recommendations are contained in an annual CAA report entitled PROGRESS REPORT - CAA RESPONSES TO AIR ACCIDENTS INVESTIGATION BRANCH (AAIB) SAFETY RECOMMENDATIONS. The absence of errors and omissions cannot be guaranteed. This document is published by the Safety Investigation and Data Department, Safety Regulation Group, Civil Aviation Authority, Aviation House, Gatwick Airport South, West Sussex, RH6 0YR. Tel: 01293 573220 Fax: 01293 573972 Telex: 878753 watched it, "The engine spluttered once or twice then stopped completely, almost immediately. The right wing dipped right down, the tail came up and the plane began spiraling anticlockwise to the ground." As the aircraft descended, it continued to spiral with the tail higher than the nose. She could not be certain of the number of turns but counted at least seven. At one point, she had the impression that the aircraft seemed to hesitate, pointing in her direction before continuing the spiral. As her concern mounted, she took out her mobile phone and began to dial the emergency services. The aircraft disappeared behind some trees and shortly afterwards a plume of black smoke appeared. The police arrived very quickly and she accompanied them to the scene. Another witness near Banbury also saw the aircraft flying in a straight line before the sound of the engine stopped and the aircraft went into a spinning manoeuvre. She thought that it described about five turns before she lost sight of the aircraft. During these manoeuvres, she could hear a noise "as if an attempt was being made to restart the engine"; she could not see if the propeller was turning. Both of these witnesses considered that the aircraft was at a reasonable height and estimates from the position of one of the witnesses indicated an altitude of around 4,000 to 5,000 feet agl. One further witness only saw the aircraft during the spinning manoeuvre at an estimated 500 to 600 feet agl. This witness could neither see any smoke or flame, nor hear any engine noise. He described the rate of rotation, and the aircraft attitude, as constant but thought that the radius of turn was increasing as the aircraft descended. None of the witnesses saw the aircraft impact the ground.

The Fire Service was alerted at 1353 hrs and the first vehicle was on the scene of the accident at 1403 hrs. By then, the fire was smouldering and was brought under control using foam extinguishant. Fire vehicles from both Banbury and Kidlington attended the scene.

FOLLOW UP ACTION

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

Recommendation 2003-76

The Civil Aviation Authority should conduct a review of the present advice regarding the use of parachutes in GA type aircraft, particularly those used for spinning training, with the aim of providing more comprehensive and rigorous advice to pilots.

CAA Response

The CAA accepts this recommendation. A review of published advice has been conducted. Changes to the current advice will be published in the General Aviation Safety Information Leaflet (GASIL) and included in the next issue of Safety Sense Leaflet 19 and LASORS 2004, to be published in January 2004.

CAA Status - Open