

Follow-up Action on Occurrence Report

ACCIDENT TO ROBINSON R44 RAVEN I, G-OUEL, NEAR TEVIOTHEAD, SCOTLAND ON 30 JULY 2003

CAA FACTOR NUMBER	:	F22/2005
FACTOR PUBLICATION DATE	:	07 June 2005
OPERATOR	:	Private
CAA OCCURRENCE NUMBER	:	2003/05069
AAIB REPORT	:	Bulletin 5/2005

SYNOPSIS

(From AAIB Report)

The helicopter departed on a VFR flight from a private site near Hawick in Scotland to route to Barton Airfield in Manchester. Initially it flew southwards at 1,500 feet amsl but as it approached hills, whose tops were reportedly covered by an area of low cloud, it turned away from the planned route and probably entered cloud. As the turn continued the helicopter accelerated, entered a rapid descent and the main rotor blades struck the tailboom. Most of the tailboom detached, the rotors virtually stopped and the helicopter impacted the ground at the bottom of a valley, fatally injuring the pilot.

A number of military aircraft were operating in the area at the time of the accident but none of these could have influenced the safe progress of the flight. No signs of pre-accident malfunction of the helicopter were found, but full determination of its pre-impact serviceability was prevented by extensive post-crash fire damage. The available evidence indicated that the accident followed a main rotor blade strike on the tailboom, probably caused by excessively low rotor RPM. The control loss and low rotor RPM may have resulted from spatial disorientation and mishandling of the controls but the possibility that aircraft malfunction had contributed to the accident could not be eliminated.

FOLLOW UP ACTION

The two Safety Recommendations, made by the AAIB following their investigation, are reproduced below, together with the CAA's responses.

Recommendation 2005-21

It is recommended that the Robinson Helicopter Company consider including in the R44 and R22 Pilot's Operating Handbooks, a specific warning highlighting the possibility of a rapid and excessive collective pitch demand causing a hazardous loss of rotor RPM, together with guidance on the appropriate handling of the collective lever.

CAA Response

This Recommendation is not addressed to the CAA.

The current status and the final responses to all Safety Recommendations are contained in an annual AAIB report entitled AIR ACCIDENTS INVESTIGATION BRANCH (AAIB) SAFETY RECOMMENDATIONS AND RESPONSES.

(HELICOPTER CRASHED IN TRANSIT)

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. It is published by the Safety Investigation and Data Department, Safety Regulation Group, Civil Aviation Authority, Aviation House, Catwick Airport South, West Sussex, RH6 0YR Tel: 01293 573220 Fax: 01293 573972 Telex: 878753.

Recommendation 2005-22

It is recommended that the Federal Aviation Administration (FAA) and the European Aviation Safety Agency (EASA) reassess the 'corrective action time delay' in reducing the collective control after sudden power loss on a single-engined helicopter, with the aim of ensuring, as far as possible, that the minimum reaction time required is realistically within the capability of an average qualified pilot.

CAA Response

This Recommendation is not addressed to the CAA.

CAA Status - Closed