Safety Regulation Group
Safety Investigation and Data Department

Follow-up Action on Occurrence Report

ACCIDENT TO AS350BA ECUREUIL, G-COPT, AT FAIROAKS AIRPORT ON 16 MAY 2002
(HELICOPTER WENT OUT OF CONTROL DURING AFTER START CHECKS)

CAA FACTOR NUMBER	:	F11/2003
FACTOR PUBLICATION DATE	:	14 May 2003
OPERATOR	:	Private
CAA OCCURRENCE NUMBER	:	2002/03052
AAIB REPORT	:	Bulletin 4/2003

SYNOPSIS

(From the AAIB Report)

The pilot had planned to take three passengers on a local flight. He completed his usual walk round checks, explaining his actions to his passengers. He then ensured they were seated with their harnesses properly secured before he secured himself into the right-hand pilot's seat. The pilot then carried out the normal pre-start checks and distinctly remembered adjusting the friction on both the collective and cyclic levers. Whilst he could not specifically recall checking that the collective lever was latched down, this formed part of the normal procedure and the pilot was therefore sure that he did so.

The pilot started the engine, again explaining what he was doing to one of the passengers seated in the front left-hand seat. With the rotors turning, he then recalled depressing the hydraulic test button on the central console and rotating the cyclic as required during the after start checks. He remembered little after this point other than the collective lever jumping up and a vague recollection of fighting with the aircraft as it went out of control. A witness reported seeing the aircraft start and then slew to the left before rolling to the right and falling onto its side.

The pilot's next recollection was lying on his right shoulder with voices shouting "GET OUT". He undid his harness and together with the passengers climbed out of the aircraft through the door on the left-hand side which had been pushed open. The airfield fire and rescue service was quickly at the scene. There was no fire and the fire fighters helped the four occupants out of the aircraft before turning off the aircraft master switch and fuel selector. As the aircraft fell onto its side, the main rotors contacted the ground and broke up sending pieces flying across the apron. One piece had sufficient energy to penetrate a nearby metal hangar. Fortunately, there were no injuries to surrounding personnel.

FOLLOW UP ACTION

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

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

Recommendation 2003-07

The Civil Aviation Authority should review Change Sheet 2 Issue 1 to the AS350BA Rotorcraft Flight Manual (Revised Hydraulic Accumulator Test) that requires the hydraulic accumulators to be exhausted during the pre-takeoff accumulator test.

CAA Response

The CAA accepts this Recommendation.

The CAA has reviewed the Change Sheet 2 Issue 1 to the AS350BA Rotorcraft Flight Manual (Revised Hydraulic Accumulator Test) and has concluded that it should be retained in an amended form. Accordingly, on 26 March 2003, the CAA issued Change Sheet Issue 2 which includes a statement that during the pre-takeoff accumulator test it is not necessary to continue the test until the hydraulic accumulators are exhausted.

CAA Status - Closed