Gemini Flash II, G-MTBW, 15 April 1997

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Aircraft Type and Registration: Gemini Flash II, G-MTBW

No & Type of Engines: 1 Rotax 503 piston engine

Year of Manufacture: 1986

Date & Time (UTC): 15 April 1997 at 1615 hrs

Location: Aldridge 'Airport' near Walsall

Type of Flight: Private

Persons on Board: Crew - 1 - Passengers - 1

Injuries: Crew - Fatal - Passengers - Serious

Nature of Damage: Microlight destroyed

Commander's Licence: Private Pilot's Licence

Commander's Age: 59 years

Commander's Flying Experience: 81 hours (of which 60 hours were on type)

Last 90 days - 32 hours

Last 28 days - 16 hours

Information Source: AAIB Field Investigation

Background

'The Airport' at Aldridge was opened in 1935 as a municipal aerodromeby Walsall County Borough. It had three grass strips, the longestof which was 890 metres. After WWII its runways became too shortfor aircraft of the day and the aerodrome fell into disuse. Althoughit still bears the name 'The Airport', the disused aerodrome isnow a public amenity park controlled by Walsall Borough Council. Numerous sporting and leisure activities take place within thepark which has some hard surfaced tennis courts and a social clubbuilding in the northern most corner. In winter there are severalfootball pitches marked on the grass, each with its own goalpostswhich are left standing for the season. In early April the postswere removed to make way for cricket pitches.

Although model aircraft flying was the only aviation activity with formal permission to use the park, about three years agoa senior member of a well established aero club north of

Birminghamobtained informal permission to land microlight aircraft thereprovided that there were no football matches in progress and subject to there being no complaints from the public. In recent monthsseveral microlight aircraft have landed in the park during the evening and on Sunday lunchtimes, apparently without any complaint from the public. There is no designated landing strip and themicrolights have usually landed on the western or southern fringes of the park. The pilot of G-MTBW had landed there at least three times before in the company of one of the flying club's more seniormembers who had briefed him on the preferred landing procedure which was to approach along the southern boundary of the parkand land on the western side. For all three previous approaches the surface wind had favoured a landing in a north-easterly direction. There is no windsock at 'The Airport' and no reliable source of local wind information such as a nearby factory chimney.

The microlight was owned exclusively by the pilot who stored itat the aero club. The pilot commenced flying training with theclub in September 1995 and qualified for his licence a year later. In April 1996 whilst part way through his flying training hepurchased G-MTBW and had flown only this machine since July 1996. He was voted the club's 'best student of the year' in 1996 andhad demonstrated his ability to cope with real and unexpectedengine failures on two occasions, having landed his machine withoutinjury or further damage.

The microlight was equipped with an aeronautical radio transceivercoupled to an intercom system. The transceiver was carried ina bracket attached to the keel tube; the battery was carried ina side pocket and the intercom box was mounted inside the front-seatframe. Headsets worn under the occupants' flying helmets enabledconversation between them and allowed the pilot to converse onthe radio. There was no ground radio at the club airfield andthe pilot had been discouraged from contacting Birmingham ATC.

History of Flight

On the day of the accident the pilot arrived at the club airfield with two friends with the intention of taking each of them flyingin the rear seat of his microlight. The machine was prepared for flight by attaching the previously rigged 'flex wing' to the dual seated 'trike unit' and the pilot carried out a detailed pre-flight inspection. He then 'booked out' for a local flight with the first passenger and took off uneventfully at about 1545 hrs.

The synoptic weather situation was governed by a ridge of highpressure established over the area with light and variable surfacewinds. Visibility was more than 50 km at nearby Birmingham Airportwith a few clouds at about 5,000 feet altitude. The light windwas, however, unusually variable in direction. The 1520 hrs observationat Birmingham recorded extremes in wind direction of 260°through north to 090° whereas the 1550 hrs observation recorded extremes in direction from 240° through south to 160°. A meteorological aftercast stated that the general wind flowat 2,000 feet altitude was 100° at 10 kt and at 1,000 feet it was 070° at 5 kt. Witnesses at the accident sitestated that the surface wind was from the north east at about 10 kt.

In daylight hours the central area of 'The Airport' is frequently used by people exercising their dogs and there were several peopleso doing when G-MTBW arrived over the park at about 1610 hrs. The microlight was first noticed approaching from the north westin level flight with the engine running smoothly. Overhead thepark the engine noise reduced as if it had been throttled back. The machine descended, apparently under control, in a left turnin such a manner that all the witnesses thought it was carryingout what appeared to them to be an approach and landing. However, during the final left turn onto a westerly heading the microlight's right wing was seen to strike a poplar tree at about

30 feet agl. Witnesses heard the engine power increase and saw the machineoscillating in roll before striking the ground heavily in a rightwing low attitude.

After the crash several witnesses came to the aid of the occupants. The pilot was motionless and lying on the passenger's leg. Thepassenger was talking but trapped by his right leg and so onewitness cut the pilot's lap harness to enable them to move thepilot and release the passenger. The autopsy revealed that thepilot had died at impact from internal injuries. The passengeralso suffered from internal injuries and several broken ribs.

It was the passenger's third flight in a microlight. He recalledthat the take off was normal and that they flew towards Walsall. Near the town the pilot decided to return to the departure airfieldwhere he intended to land and exchange passengers. As they turnedleft the pilot throttled back the engine to reduce noise. Thepassenger remembered remarking to the pilot on the intercom systemabout the large number of green football pitches he could see('The Airport') when there was a noticeable increase in backgroundnoise in the earpieces of his helmet-mounted headset. The passengerwas aware that the intercom had partially failed and he knew thatthe pilot had suffered similar intercom problems during previousflights. Because of this partial failure the pilot's reply wasinaudible but he gestured to the passenger by pointing downwardstowards the football pitches. The passenger then saw the pilotbending down, apparently trying to reach something within thecockpit under the control bar. At the same time he became awareof a steep spiral descent through approximately two revolutions. Late on during the descent he saw the poplar tree which the aircrafteventually hit; he was sure that the pilot had also seen the treebecause at that point the engine power increased and he felt surethe pilot was 'going around' in order to avoid the tree. He wasaware that they were travelling quite fast (between 40 and 50kt) and climbing when the machine hit the tree.

Wreckage examination

The aircraft had crashed in the north-eastern corner of 'The Airport', with the ground marks indicating that the impact track was around277° magnetic. A line of four poplar trees, which borderedthe tennis court, extended in an approximately south-westerlydirection from the edge of the field. It was clear that the aircraft'sright wing had struck the most westerly tree some 10 metres abovethe ground. The impact point was approximately 75 metres, andon a bearing of some 265°, from the tree. It was thus apparentthat the impact with the tree had caused the aircraft to turnto the right by more than 12°.

The aircraft had landed heavily on its right mainwheel, resultingin a structural collapse of the right-hand side of the trike. This had caused the righthand corner of the 'A' frame (thecross-tube of which constitutes the control bar) to contact theground, which then rotated the wing to the right relative to thetrike. The 'monopole' (the vertical structural member of thetrike that attaches to the wing) had suffered a bending failureduring the ground impact. The aircraft had come to rest approximately10 metres from its initial point of impact. Additional evidenceof a high descent rate was indicated by the fact that the 'kingpost' on top of the wing (which is attached by cables to variouspoints on the wing upper surface), had suffered a compressionfailure due to downwards flexing of the wing at impact. The onlyother significant structural failure was the right wing leadingedge tube, which had failed 1.6 metres from the tip. The onlycable failure was one of the dual redundant flying wires that connected the bottom of the 'A' frame to the underside of the right wing. Fragments of propeller blade leading edge tape werefound embedded in the strands, indicating that the cable had beensevered by the propeller during the impact.

Examination of the tree revealed that several of the lighter brancheshad been severed but that the central trunk, which was approximately 100 mm in diameter at that height, had remained intact. It hadhowever been struck hard enough to remove a section of bark. The fabric on the underside of the wing had been smeared with foliage and bark deposits: these marks were orientated in a spanwiseas opposed to a chordwise direction, indicating that the leading edge wing tube had failed upon striking the tree, and then trailed rearwards.

Immediately adjacent to the ground impact mark made by the rightmainwheel was a cut in the turf made by the propeller. Fragmentsof wood from the propeller were scattered over a wide area, withthe degree of fragmentation suggesting that the engine had been delivering considerable power at impact. The fuel tank was morethan half full of fuel and had remained intact apart from a damaged filler cap. Fuel spillage was confined to a small quantity released as a result of the float chamber bowl becoming detached from the carburettor.

A more detailed examination of the wreckage revealed that theunion between the fuel line and the selector valve was weepingslightly. The presence of an oily deposit around the union suggestedthat fuel had been seeping out for some time, with the petrolhaving evaporated from the two-stroke mixture. It was noted thatthe standard end-fitting on the fuel line had been replaced withan ill-fitting jubilee clip. Whilst the condition of the uniongave rise to the possibility of air being entrained into the fuelinlet line, the indications of power at impact, plus the witnessstatements, suggested that engine operation had not been affected. The intercom unit-had broken up during the groundimpact, and could not be checked.

This aircraft was equipped with 'roll tips' on the wing, a featurewhich allows incidence washout at the tips in order to improve handling close to the stall. The wing fabric is bolted to the tip portion of the leading edge tube, which is able to rotate, on a bearing, relative to the inboard (ie fixed) section of thetube. The effect of this arrangement is to allow the wingtipsto off-load the aerodynamic lift by rotating to a lower angle of incidence. A spring-loaded button locates into one of a series of five holes in the inboard section, which limits the minimumangle to which the tip can rotate. This facility is provided as a method of trimming the wing in the event of a tendency for the aircraft to turn when in straight and level flight. Examination of GMTBW revealed that the button mechanism had been damaged such that the button was not located in any hole. In this condition, the tip portion would have been unconstrained in rotation, althoughin fact the tension in the wing fabric acts to restrict tip movement. After removing the left and right tip assemblies, it was found that the left tip bearing was comparatively new in appearance, with fresh looking grease applied to the area. Additional evidence of maintenance activity in this area was provided by the use of an aluminium pop rivet in the assembly. The corresponding itemon the right wing, which is presumed not to have been touched since manufacture, was of stainless steel and of a smaller diameter.

The aircraft log book contained no entries concerning work onthe left wingtip, and the aircraft manufacturer had no recordof any parts, such as the replacement bearing, being ordered bythe pilot who was the owner at the time of the accident (therewere two previous owners). The aircraft had a current Certificateof Validity on its Permit to Fly, and had had all its annual inspectionsnecessary for the issue of successive Certificates. However,neither of the two BMAA Inspectors associated with the aircraftwere aware of any work on the wingtip, and stated that they would expect the owner of an aircraft to inform them of any such activity, thus giving them the opportunity of inspecting it.

The aircraft manufacturer conducted a flight test subsequent to the accident, in which a wingtip was deliberately unconstrained by its index button. The results indicated no untoward effects of operating

the aircraft in this condition, although there was the possibility of lateral trim problems close to the stall.

Analysis

When powered after the accident, the pilot's radio was found tobe tuned to Birmingham Airport's ATIS (Automatic Terminal InformationSystem) which broadcasts the wind direction at the airport. If the pilot had listened to this broadcast just before the accident, he would have heard the 1550 hrs wind observation which was 060°/06kt but variable in direction from 240° through south to 160°.

The passenger thought that the pilot might have been attempting a forced landing at 'The Airport' after suffering an engine failureand that he had been attempting to start the engine by reachingdown to operate the starting cord when the engine suddenly re-started. This was inconsistent with the bulk of the witness evidence. It is more likely that the pilot was reaching down to adjust the intercom and, having failed to correct the problem, he decided the spur of the moment to land at 'The Airport', where he hadlanded before, to rectify the problem. Unfortunately he attempted tight spiral descent over the central area whilst an easterlywind (at 500 feet and above) drifted the microlight towards thetree belt surrounding the social club and tennis courts. Thepilot appears to have misjudged the final turn, when the windwas in the microlight's rear left quarter, resulting in a downwindand downhill approach towards the trees. He saw them and attempted avoid them by climbing but the right wing tip struck the trunk of the leftmost tree. Failure of the leading edge tube on impactresulted in loss of roll control. However, it is possible that the machine stalled whilst the pilot was attempting to avoid thetrees and that loss of full control preceded impact.

In accordance with their usual practice, the BMAA will publish the details of this accident in a future issue of their magazine. It is anticipated that emphasis will be placed on the necessity of any work conducted by owner/pilots on their aircraft beingnotified to the appropriate inspectors.