

# Reims Cessna F150M, G-BFRO

## AAIB Bulletin No: 1/98 Ref: EW/C97/5/2 Category: 1.3

<b>Aircraft Type and Registration:</b>	Reims Cessna F150M, G-BFRO
<b>No &amp; Type of Engines:</b>	1 Continental O-200-A piston engine
<b>Year of Manufacture:</b>	1977
<b>Date &amp; Time (UTC):</b>	6 May 1997 at 0730 hrs
<b>Location:</b>	3 nm north of Cumbernauld Airfield, Scotland
<b>Type of Flight:</b>	Aerial Photography
<b>Persons on Board:</b>	Crew - 1 - Passengers - None
<b>Injuries:</b>	Crew - Fatal - Passengers - N/A
<b>Nature of Damage:</b>	Aircraft destroyed
<b>Commander's Licence:</b>	Basic Commercial Pilot's Licence with Instrument Rating
<b>Commander's Age:</b>	22 years
<b>Commander's Flying Experience:</b>	731 hours (of which 241 were on type) Last 90 days - 151 hours Last 28 days - 13 hours
<b>Information Source:</b>	AAIB Field Investigation

## History of the Flight

The pilot had planned to conduct aerial photography in an area to the north of Cumbernauld Airport. He arrived at the airport at approximately 0700 hours and completed the pre-flight checks on the aircraft; whilst at the airport he did not obtain any meteorological information. The forecast conditions for the area were for a visibility of 40 km with no significant weather or cloud and with a temperature of 0°C at 1,000 feet. However, there was a fresh to strong north-westerly wind which was forecast to produce moderate turbulence below 6,000 feet. An aftercast obtained from the MetOffice confirmed the validity of this forecast and noted that the wind at 2,000 feet was 330/30 kt.

The aircraft took off from Cumbernauld Airfield at 0719 hours. Analysis of recorded radar data from the radar head at Lowther Hill, in Dumfries and Galloway, indicates that after take off the aircraft flew on a northerly track directly towards the area of Carron Bridge which is on the B818 road 1 km to the east of the Carron Valley Reservoir. The radar data shows that the aircraft then

generally followed the B818 road in an easterly direction towards Denny, but that it was manoeuvring around the houses and farms along this road. Photographs obtained from the film used during this flight show these identifiable buildings in the same order suggested by the radar data. The final recorded radar data shows the aircraft manoeuvring 800 metres to the north of the crash site at 0728 hours.

At about this stage the aircraft was observed to be flying a series of turns in an anti-clockwise direction; all of the witnesses described the aircraft flying very slowly at a height estimated to be between 150 to 300 feet above the ground. The aircraft motion was described as 'swaying from side to side' with the 'nose dipping and rising'. The aircraft then banked abruptly and went down nose first crashing onto the B818 before coming to rest in an adjacent field. Shortly after impact a fire started in the wreckage, a number of passers-by attempted to quell the fire with water from a nearby stream but they were moved back by the police who feared an explosion; the fire services arrived at 0746 hours. The pilot had sustained fatal injuries in the crash.

### **Pilot Experience**

The pilot had obtained his Private Pilot's Licence in 1992 and upgraded to a Basic Commercial Pilot's Licence (BCPL) in 1995; he also held an Instrument Rating and a Multi-Engine Rating. He had recently completed the requirements for a Commercial Pilot's Licence (CPL) which was issued in May 1997. He had spent the previous two summers flying for parachuting clubs and had then gone to the United States in February 1997 for two months to fly the Cessna 152 in order to increase his total flying hours. When he returned home in April 1997 he contacted an aerial photography company who offered him employment as a pilot/photographer. As part of his familiarisation with this role he was given a full demonstration of how to operate the camera. When he first used this in the air there was another pilot flying the aircraft, he then gradually assumed more of the responsibilities for flying the aircraft whilst taking photographs until, after four flights, he was able to conduct the entire operation unassisted. After two solo training flights, during which he produced satisfactory aerial photographs, he positioned the aircraft at Cumbernauld Airfield from where it was planned to operate during the summer.

### **Medical and Pathological Information**

The pilot had earlier been diagnosed as having a malignant disease of his lymphatic system which had been successfully treated with chemotherapy. One of the agents used in this treatment is known to be toxic to the heart. During the post-mortem examination extensive fibrosis was noted in the heart and this could possibly have given rise to a disturbance of cardiac rhythm which could have led to the collapse of the pilot before the accident. Despite this evidence it is not possible to determine whether or not the pilot was conscious at the time of impact.

As a consequence of his medical history the pilot's Class 1 medical certificate was endorsed with a restriction that limited him to flying 'as or with a co-pilot'; he also held a valid and unrestricted Class 3 medical certificate. A Class 1 or Class 2 medical certificate is required for professional flying, whilst a Class 3 medical certificate is only applicable to private flying. The CAA generally regard an individual who is fit for a Class 1 medical certificate with an 'as or with co-pilot' restriction as being fit for unrestricted Class 3 medical certification because a higher standard of medical fitness is considered necessary for professional flying purposes than for private flying. This pilot, when flying solo, was therefore only flying within the privileges of his licence when engaged in private flying.

With the advances in the treatment of many cancers the problem of patients who have been successfully treated and wish to return to flying will become more common. Many of the modes of treatment are themselves very toxic. This accident has demonstrated that occult cardiotoxicity may have occurred and other organ damage may occur with other forms of treatment. It is therefore recommended that the Medical Department of the CAA Safety Regulation Group should obtain advice from an appropriate source as to the measures they should employ to detect toxic heart or other organ damage when examining candidates for medical certificates who have been treated for cancer (Recommendation 97-52).

### **Examination of the wreckage and airworthiness aspects**

The aircraft crashed on to the B818 road about three quarters of a mile north-west of the village of Frankerton. Marks on the road and damage to the aircraft itself showed that it had descended on to the road upright but banked to the left and in a steep nose down attitude on a heading of 240 M. It had then bounced over the fence and hedge at the side of the road and had come to rest in the field alongside the road. Both fuel tanks had been ruptured and a fire had badly damaged the nose and cockpit.

The body of the pilot, the only occupant, was in the left seat. The lap belt of his safety harness had been partially consumed by fire but the buckle was found locked. The diagonal strap was not attached, as found. The body was in a seated position but collapsed forward and a camera body was found under the torso, effectively on the pilot's lap. A detachable telephoto lens was found beside the pilot's legs. The camera body and lens both had damage which was consistent with them having been broken apart. The full weight of the camera and lens was 2.6 kg and their assembled length was 30.5 cm.

Examination showed that the aircraft had been structurally intact at impact with all flying and control surfaces properly attached. There were some mechanical failures in the flying control system but these appeared to have been caused by the impact with the ground and no failures or disconnections were identified as having occurred before the crash. The flaps were retracted.

The propeller had become detached in the crash. One blade was simply bent rearwards but the other was severely twisted and scored and showed all of the characteristics normally associated with high power at impact. There was also a gouge in the road surface which, because of its position relative to the other marks made by the aircraft, was attributed to the propeller. It was concluded that the propeller had been rotating under power but the severity of the impact with the road had almost stopped the propeller and had broken it off within half a rotation. Both fuel tanks had suffered bulging distortion and this indicates that there had been a large amount of fluid in them at impact.

The throttle was found partially open and this was consistent with the indications of power from the propeller. The fuel valve was open. The fuel/air mixture control was at 'FULLY RICH'. The carburettor air control was selected to 'COLD' but given the indications of power being supplied to the propeller at impact it cannot be shown that a power loss due to carburettor icing had been encountered in flight. The fuel primer was locked. The magneto switch was at 'OFF' and its position was, therefore, in conflict with the evidence that the engine was producing power at impact. The key handle had been bent downwards and slightly twisted. The direction of twist was towards the 'OFF' position and it seems probable that the key was rotated towards the 'OFF' position during the crash by some impact.

The aircraft crashed at a nose down angle of about 20° below the horizontal and banked about 10° to the left. There was no evidence to indicate that it was in a stalled condition at that time but it could have been in a late stage of recovery. The pointer on the Air Speed Indicator was positioned at 82 mph (normal stalling speed is 55 mph) but no evidence could be found to relate this instrument position to impact. The internal mechanism, which balances a pressure capsule against a spring may simply have settled at this position during the fire.

The pilot's seat was examined. The seat back had not collapsed rearwards and damage to the seat rail and the pin which engages the rail to lock the seat in position showed that the seat had been properly located and locked at impact.

The records showed that the aircraft had been maintained to the required maintenance schedule with the exception of the period from 24 April until 1 May 1997 when it was operated outside the period of validity of the previous maintenance certificate; it was within the 50 operating hours limit but was outside the calendar limit of 62 days. However, an inspection was carried out when the aircraft arrived at Cumbernauld.

### **Aerial Work**

The business operation of the registered owners of G-BFRO included arrangements for the aerial photography of properties. The prints of these photographs were then offered for sale to the property owners or the general public. In order to accomplish this task the company provided the pilot with an aircraft for which they paid the operating costs; they also provided a hand held camera fitted with a zoom lens, a supply of films and a map indicating the areas to be photographed. The pilot was paid for the exposed films with the proviso that these prints were of a satisfactory standard. Article 119 (1) of the Air Navigation (No 2) Order 1995 defines aerial work as 'any purpose (other than public transport) for which an aircraft is flown if valuable consideration is given or promised in respect of the flight or the purpose of the flight.' This flight appears to fall within the definition of aerial work and the pilot was thus required to hold a professional pilot's licence with an appropriate medical certificate (Class 1 or 2). The medical restrictions on this pilot's licence prohibited him from flying in a professional capacity except 'as or with a co-pilot'.

### **Single pilot aerial photographic operation**

When flying as a single pilot and taking aerial photographs with a hand held camera the aircraft would typically be flown at a speed of about 60 KIAS and at heights down to 700 feet agl. Once over an appropriate location the pilot would then release the flight controls for a period of 3 to 5 seconds whilst using the camera to take photographs. The camera used for this task was a Cannon EOS 1N fitted with a 35/350 mm lens; the camera body was 16 cm wide by 11 cm in height and with the lens fully extended was approximately 24 cm long, the combined weight of the lens and camera was 2.6 kg.

Flight at low level in uncontrolled airspace requires constant and close attention to the avoidance of collision with other aircraft or even ground based obstructions, this requires a positive and continuous monitoring of the visual scene by the pilot. When a pilot is flying an aircraft and regularly taking photographs with a hand held camera fitted with a large zoom lens he is incapable of maintaining an adequate look out for other aircraft or obstacles. Furthermore, the pilot's ability to cope with an engine failure or difficult wind conditions and the associated down draughts whilst flying at such low speeds and close to the ground must be doubtful. This problem would be compounded by the presence of a loose, bulky camera in a small cockpit. A second crew

member, allowing for clearly defined responsibilities for the separate tasks of photography and piloting, is a much safer option. It is therefore recommended that the CAA should consider suitable regulations relating to the conduct of aerial photography of a commercial nature in order to eliminate the dual role of pilot and photographer (Recommendation 97-53).

## **Safety Recommendations**

### **Recommendation 97-52**

It is recommended that the Medical Department of the CAA Safety Regulation Group should obtain advice from an appropriate source as to the measures they should employ to detect toxic heart or other organ damage when examining candidates for medical certificates who have been treated for cancer.

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