

Aerospatiale AS332L Super Puma, G-TIGT, 4 January 1996

AAIB Bulletin No: 6/96 Ref: EW/C96/1/2 Category: 2.1

Aircraft Type and Registration:Aerospatiale AS332L Super Puma, G-TIGT

No & Type of Engines:2 Turbomeca Makila 1A turboshaft engines

Year of Manufacture:1983

Date & Time (UTC):4 January 1996 at 1720 hrs

Location:Aberdeen Airport

Type of Flight:Public Transport

Persons on Board:Crew - 2 Passengers - None

Injuries:Crew - None Passengers - N/A

Nature of Damage:Main rotor destroyed; tail boom assembly detached and fuselage damage on left hand side

Commander's Licence:Airline Transport Pilot's Licence

Commander's Age:51 years

Commander's Flying Experience:11,800 hours (of which 7,200 were on type)

Last 90 days - 117 hours

Last 28 days - 43 hours

Information Source: AAIB Field Investigation

History of flight

Both pilots reported for duty at 1000 hrs on the day of the accident each having had at least two days rest. The helicopter G-TIGT was airborne at that time and they took control from another crew at about 1125 hrs with the rotors running. The crew then completed multiple sectors to and from installations in the Scott Field involving some five and a half hours flighttime. The helicopter remained fully serviceable with rotors running throughout that period and it landed in darkness at 1708 hrs on Runway 19. The commander then taxied the aircraft on its wheels to the company apron; the taxiway routing required several turns and the commander noticed nothing unusual about the helicopter's response to his control inputs. In accordance with company standard practice, the passengers and cargo were off-loaded on the apron with the rotors running. The commander then taxied the helicopter on a north-easterly heading towards the spot where it would eventually be shut-

down. A weather warning issued by the airport forecasts south-south-easterly winds of mean speed 15-20 kt with gusts of 30-35 kt at times and so it was decided to park the helicopter facing into wind. Obstructions on the apron dictated that the final turn onto a southerly heading had to be a tight turn and, initially, the pilot eased the helicopter to the left before reversing the turn to the right. As he did so, the co-pilot (seated on the left side) looked to his left and behind the helicopter to ensure that the tail rotor remained clear of parked ground equipment whilst the commander turned off the landing lights and applied right pedal to execute a right turn under the guidance of a marshaller. During the turn the helicopter began to roll to the left; the commander applied full right cyclic control but this was ineffective in containing the roll and the helicopter fell onto its left side. As it fell the main rotor blades struck the apron surface and disintegrated. Both pilots then took appropriate action to shutdown the engines and electrical systems before vacating through the commander's door.

The marshaller who was in front of but to the right of the helicopter saw the nose wheel begin to castor as the machine started to turn towards him, but as it did so he saw the right main wheel lift clear off the ground. The helicopter continued to roll over and so he turned around and ran to escape the path of debris from the main rotors. The only other person near the helicopter was driving a tractor behind it and to its right and well clear of the debris path. He felt a gust of wind on his cheek at about the time the helicopter started to roll over and he too saw the right main wheel lift clear of the ground. He had seen this happen several times before to Super Pumas turning tightly but previously they had always recovered from the roll. Other ground handlers had also seen similar events but there was no evidence that such observations had ever been reported to the Operations Department.

As the main rotor blades struck the tarmac, their plane of rotation was towards the airport's main Terminal. Several minor pieces of metallic debris reached the Terminal which was 350 metres from the accident site. The largest piece penetrated a window at the front of the Terminal with a very loud bang and struck an office wall on the ground floor. Another piece penetrated the cladding on the exterior wall above the upper floor and was trapped by the suspended ceiling where it did little damage. Two windows in a nearby office building and the side window of a parked car were also struck and smashed. Only one piece of debris struck a person, an airport employee who was walking in front of the Terminal. A small piece of metal struck him on the shoulder but did not injure him. One parked aircraft close to the helicopter also received minor damage to its landing light.

Wreckage analysis

The aircraft was removed from the apron by agreement with the AAIB co-ordinator before the arrival of the AAIB team. Examination of the helicopter showed that it had tipped on to its left side, coming to rest about 10 or 15 degrees nosedown and rolled rather more than 90 degrees to the left, so as to rest on the left side of the nose and the left sponson. This was subsequently confirmed from photographs and FDR data. During this process the main rotor blades had been progressively destroyed. The balance weights at the blade tips had been released and thrown towards the main Terminal; the less dense fragments of the composite blades had travelled shorter distances. One of the main rotor blades had struck the tailboom adjacent to the tail rotor transmission tunnel but the strike was low energy and had occurred after the blade had already lost its tip. The horizontal stabiliser had touched the ground lightly during the roll-over, however considerable inertial loading on the tail in the opposite direction had caused all the rivets to fail in shear immediately behind frame 9000, the build joint at the major change of fuselage section just behind the passenger cabin. The tail boom aft of frame 9000 did not separate but was secured only by non-structural items. The tail rotor had been struck very lightly by pieces of composite blade material but was otherwise

undamaged although a small heavy object, possibly a tip weight, had passed through the tail rotor disc and penetrated the fin, exiting on the stabiliser side.

With the helicopter on its wheels in a hangar the structure was assessed for damage. Damage had occurred to the forward fuselage where frames on the left side had been crushed in the roll-over. There was also damage to the rotor head mounting structure in the roof, and at frame 9000. All the structural damage was deemed repairable, although requiring the airframe to be returned to the manufacturer for re-jigging. Other damage was mainly to the main rotor head which had been badly distorted, however it was possible to see that no part of the transmission or flying control system had fractured completely or become detached. The engines, main gearbox and transmission components had all been shock loaded.

Flight Recorders

The aircraft was fitted with a Penny and Giles Combined Voice and Flight Data Recorder (CVFDR) together with a Health and Usage Monitoring System (HUMS). The data from the HUMS was removed from the aircraft and replayed by the Operator but proved of no use to the investigation. The CVFDR was returned to AAIB where it was replayed successfully using standard methods.

The recorder contained the last hour of aircraft audio comprising recordings of the two crew 'hot' microphone channels and that of the cockpit area microphone. The recorder also contained a recording of the last five hours of aircraft data which included the last seven flight sectors.

The recording had terminated during the latter stages of the accident due to the operation of the tailboom mounted inertia switch. The switch was designed to cut aircraft power in the event of an accident.

The recorded data showed that the aircraft made an uneventful landing at Aberdeen and proceeded to taxi towards the Bristow Helicopters apron.

The aircraft made several right and left taxiing turns before it came to a halt on 'Hotspot 3' to discharge passengers. Once all passengers had disembarked the aircraft commenced taxiing towards parking spot 1. In doing so, it made an initial right turn, followed by a left and finally a sharp right to attempt to park on the spot into wind. It was during the final right turn that the aircraft lifted its right main gear and turned over onto its left side. A summary of the turns showing change of bearing, turn rate, collective position, lateral cyclic position and yaw pedal position are shown in Table 1. The figures for lateral cyclic and yaw pedal are given as percentage movement of full travel (0% is fully left and 100% is full right).

TABLE 1 - Summary of Turns

	Bearing	Turn Rate (Deg/sec)	Collective (Deg)	Lat. Cyclic Position	Yaw Pedal Position
Right Turn	193_ to 227_	3.4	8.7	65.2%	66.9%
Right Turn	234_ to 325_	6.5	7.1	95.8%	86.0%
Left Turn	328_ to 270_	7.7	7.5	24.4%	7.3%
Right Turn	252_ to 014_	11.1	6.6	75.0%	90.9%

Right Turn	025_ to 063_	3.6	7.4	66.4%	75.6%
Left Turn	063_ to 050_	2.6	6.4	31.2%	18.2%
Right Turn	051_ to 121_	11.6	6.5	54.5%	100%

During the final right turn the voice recording revealed that the handling pilot became aware of the onset of the accident once the aircraft had achieved 6.7° of roll. He immediately applied full right cyclic and then reduced the amount of right yaw pedal but the aircraft continued to roll left. Once the main rotors struck the ground, rotor speed decayed to below 50% and the low NR aural warning was heard on the voice recording. This warning stopped once the main blades had broken off the rotor head and the shaft was allowed to rotate more freely.

The voice and data recording terminated with the aircraft on its left side at a roll angle of 94 degrees and on a bearing of 090 degrees.

Helicopter controls

The Super Puma's flight controls are all hydraulically powered. Each actuator has two cylinders in tandem supplied by duplicated hydraulic systems. Three-axis autostabilisation is provided by the automatic pilot system but it is normally disengaged for taxiing. There is also a collective yaw coupling mixer which varies the tail rotor blade incidence with collective pitch setting to counteract changes in main rotor torque. As collective pitch increases, tail rotor pitch increases by one degree per degree of collective pitch. With the collective lever fully down, maximum tail rotor pitch is 23.4° and with it fully raised the maximum pitch increases to 36.4°. Left yaw pedal decreases tail rotor pitch and right pedal increases it to oppose the tendency of the fuselage to yaw to the left due to main rotor torque. The wheel brakes are operated by toe pedals mounted on the yaw pedal assembly, but on GTIGT they were only available to the right-hand seat pilot. The brakes operate on the main wheels only.

Component Tests

The flying controls were examined in detail and could be functioned except that hydraulic power could not be applied. All the flying controls to the main and tail rotors were found to be connected and to operate correctly. The three hydraulic actuators on the main rotor head, the tail rotor pitch hydraulic actuator and the autopilot hydraulic block were removed and sent to the manufacturer for testing, which was carried out with the AAIB in attendance. The actuators were tested to the manufacturer's specification for newly overhauled components using the approved facilities and were found to function correctly and within specification, except that the left and right main rotor head actuators were found to be slightly slower than specification. In view of the minor magnitude of this discrepancy and the data obtained from the FDR it is unlikely that the actuators lagged behind the control demands.

Landing gear

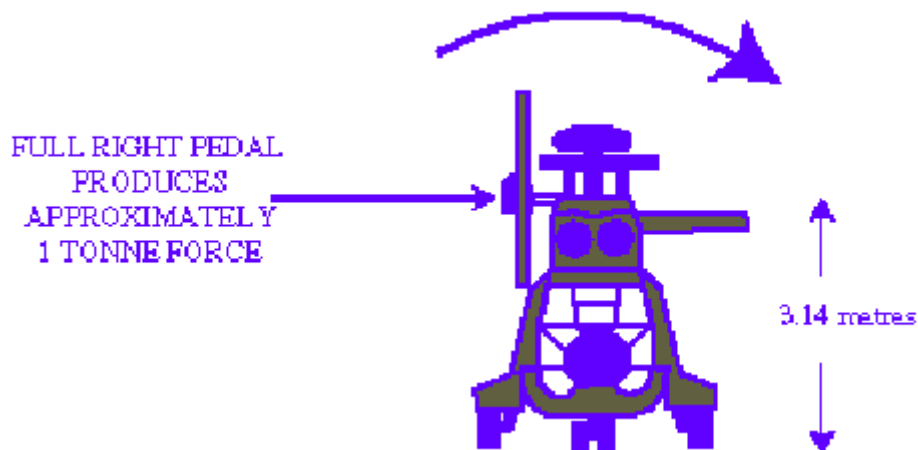
Because the aircraft was turning tightly when the accident occurred, considerable attention was paid to the condition of the landing gear. The Super Puma has a conventional tricycle undercarriage with single main wheels and a double nose wheel. The track of the main landing gear is 3 metres and the centre of gravity is about 2 metres forward of the main wheels. The main wheels are carried on

trailing arms with hydraulic oleos at the rear. The nose oleo is a fully castoring strut with a self-centring cam at the top of its stroke and a steering lock mechanism which can be selected from a lever on the cockpit floor. When engaged a red placard swings down externally into view so that a marshaller, for example, can see that the lock is engaged.

Tests showed that the nose oleo extension, castoring and self-centring functions were normal. The main oleo extensions were found to be normal and the brakes were effective, with the oleos stroking normally during the application of brakes. A strip examination of the brakes revealed no anomalies. The tyres were pressure checked, the left main tyre was low at 80 psig, the right was correct at 100 psig. The nose gear tyres were both approx. 90 psig. There is no minimum limit in the maintenance manual, however the tyres are replenished daily and 80 psig was not felt to be abnormally low. This condition would have introduced a very small, negligible, roll to the left. The steering lock was found to be serviceable and not liable to jam or engage when not selected. It was clear both from the photographs of the helicopter on its side after the accident, and from the witness statements, that the steering lock had not been selected, as the external placard was retracted. The castoring action had been checked and seemed satisfactory, however the nose oleo was subsequently removed and fitted to another helicopter, when taxi trials confirmed that this oleo was at least as free to castor as the rest of the fleet. The surface on which the helicopter was taxiing was less than perfect, however examination of the lateral and horizontal "g" traces from the FDR showed that no observable abnormal forces were introduced by the undercarriage or apron surface. There was a slope of about 4 percent on the surface, however this fell to the right and would have opposed the overturning forces.

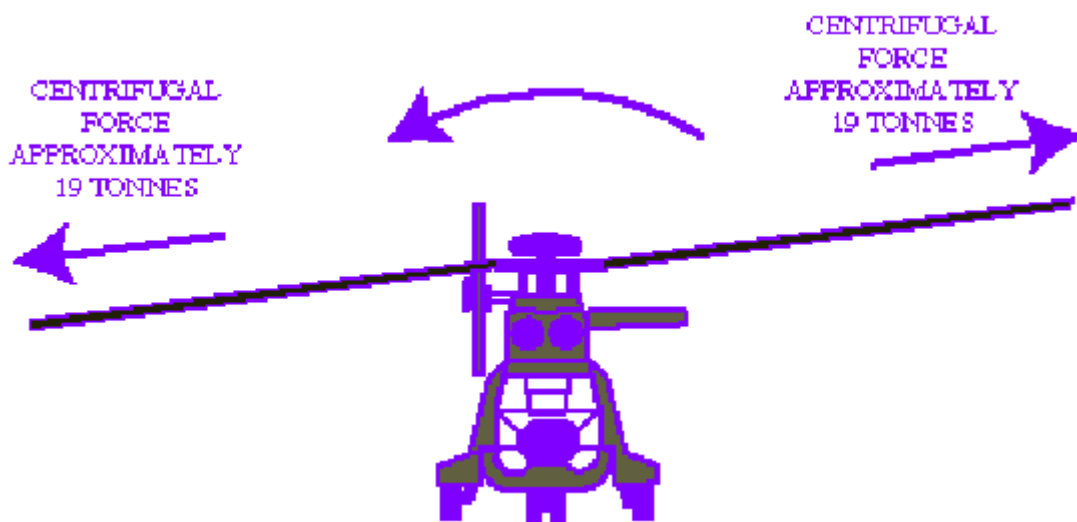
Rolling moments

When the collective lever is fully lowered for taxiing, lift from the main rotor is negligible. The major forces which produce fuselage rolling moments are weight, crosswind, tail rotor force and main rotor hinge moment. Forces arising from cornering, ground slope and fuel slosh may also be present but generally their effect is small. On the ground the helicopter's rolling axis tends to be along a line drawn between a main wheel and the nose wheel. The effect of weight is always to provide a stabilising moment provided that the centre of gravity remains inboard of this axis. On the other hand, the tail rotor force in a right turn tends to roll the helicopter to the left. The rotor hub is nominally 3.14 metres above the ground and full right pedal creates a force to the left of approximately one tonne as shown below. In some conditions the rolling moment generated is sufficient to overbalance the helicopter. This phenomenon is known as 'static rollover'.



Although the effect of weight is stabilising when the helicopter starts to roll, once the centre of gravity (cg) moves outside the rolling axis, the effect of weight is de-stabilising and the rollover becomes self-sustaining. The boundary (expressed as a roll angle) between stabilising and de-stabilising moments varies with weight and the position, particularly the vertical position, of the cg. The Super Puma's fuel is carried under the floor and the cg is highest when there is no payload and little fuel remaining. This condition, which is often encountered at the end of a flight when taxiing from a hot spot to a parking spot, is when the helicopter is most vulnerable to static rollover.

The risk of static rollover can be minimised by using in-turn cyclic roll inputs to counterbalance the destabilising moments. Left or right cyclic input causes the main rotor disc to tilt and the centrifugal forces from the blades act upon the rotor hinges to produce a strong moment which tries to align the hub with the blades. This force is transmitted to the fuselage by the rotor mast which results in a rolling moment in the same direction as the cyclic input as shown below.



Manufacturer's analysis

The helicopter manufacturer carried out an analysis of overturning forces based on the data obtained from the FDR and also the known conditions at the time. The recorded data for cyclic and collective pitch, tail rotor pitch, accelerations due to "g", roll, pitch and heading were smoothed and plotted. Roll pitch and yaw rates, and speeds were derived and plotted. By integration the track over the ground was determined. From this the manufacturer concluded that the helicopter was moving slowly and the lateral accelerations generated in the turn were not major influences. The results of this part of the analysis were cross-checked by putting the recorded control inputs into a simulation and plotting the resulting parameters such as roll pitch and heading against the same parameters recorded from the accident. A high degree of correlation was seen to exist.

For the conditions of the accident, a plot was produced of yaw pedal position versus cyclic stick roll position from the time that the aircraft departed from Hotspot 3. The plot shown at Figure 1 below showed two areas outside the normal ground stability envelope in which one or other of the main wheels would rise off the ground. No collective demand was assumed in producing this plot. The plot clearly showed that whilst either wheel could be made to rise from the ground, it was relatively easy to make the right gear do so. With no cyclic roll input to counterbalance the tail rotor moment, 90% right pedal or more would initiate a rollover.

FIGURE 1 - Cyclic and Yaw Pedal Taxi Limits

NOTE: The data in the above plot shows the ground taxiing stability boundaries of cyclic/yaw control inputs only for the specific conditions of the aircraft at the time of the accident.

By superimposing the FDR data traces for cyclic roll and tail rotor pitch it was possible to see that the control demands had moved outside the ground stability envelope for about one second at about the time the rollover began. Subsequent application of full into-turn cyclic had occurred without any reduction of tail rotor pitch demand, thereby minimising the correcting forces. Additional information available from four flights made by the operator in 1987 showed that, during the ground taxiing phase, there were a number of instances where combinations of tail rotor pitch and lateral cyclic control demands were being made which were close to the ground stability envelope. The AAIB carried out some independent check calculations of overturning and righting moments which also suggested that the tail rotor thrust was by far the most significant force, with lateral "g" providing a small additional overturning moment. With the likely forces from roll cyclic demand introduced into the AAIB's own analysis, the results indicated a large positive stability margin would have existed had right cyclic been used.

Taxying procedures

The taxiing procedure in the manufacturer's flight manual was as follows (verbatim):

- Automatic Pilot Off
- Parking Brake Released
- Nose wheel Unlocked
- Start off : full collective lever up to $9/10^\circ$; if necessary, move cyclic stick slightly forward with respect to the neutral position. Then, as requested, re-center the cyclic stick and reduce the collective pitch.
- Turns : operate the yaw pedals progressively, then, to make the turn sharper, use the differential wheel braking system. For spot turns, with a heavy gross weight, do not initiate rotation of the fuselage before taking the weight off the nose wheel, using the collective lever.

- Stopping : bring the cyclic stick to the neutral position and the collective lever to the full low pitch position, then apply the wheel brakes progressively.

Do not apply the parking brake before complete stopping of the aircraft.

CAUTION: 1/ THE AIRCRAFT WILL TEND TO BANK OUTSIDE A TURN, ESPECIALLY WHEN REACHING THE CROSS WIND POSITION. NEUTRALIZE THIS TENDENCY USING THE CYCLIC STICK.

2/ AVOID WIDE MOVEMENTS OF THE CYCLIC STICK ROUND THE NEUTRAL POSITION (NOT MORE THAN 20%), PARTICULARLY WHEN THE COLLECTIVE LEVER IS IN FULL LOW POSITION, TO PREVENT THE BLADES FROM HAMMERING AGAINST THE DROOP RESTRAINERS, WHICH CAUSES HEAVY STRESSES.

Safety recommendations

It was recommended that:

96-25 Eurocopter should revise the wording of the section of the AS332L Flight Manual covering taxiing procedures and agree this wording with the CAA. This revision should include guidance on the optimum use of collective pitch, an unambiguous statement of the limitations on the use of lateral cyclic, and include a warning of the possibility, under certain conditions, of static rollover if large deflections of yaw pedal are applied.

96-26 Eurocopter should provide AS332L operators with additional information for inclusion in training manuals on the factors affecting the potential for rollover whilst ground taxiing together with the appropriate preventative measures.

96-27 The CAA should include in the Helicopter Operational Recording Project, which uses AS332L Super Puma data, exceedance triggers that highlight critical combinations of yaw pedal and lateral cyclic which are near the boundary of that required to induce roll-over while ground taxiing.