

Piper PA-28-140, G-BBLA

AAIB Bulletin No: 3/97 Ref: EW/C96/9/6 Category: 1.3

Aircraft Type and Registration:	Piper PA-28-140, G-BBLA
No & Type of Engines:	1 Lycoming O-320-E3D piston engine
Year of Manufacture:	1971
Date & Time (UTC):	25 September 1996 at 1238 hrs
Location:	2 nm west of Southport Pier
Type of Flight:	Instruction
Persons on Board:	Crew - 2 - Passengers - None
Injuries:	Crew - 2 - Fatal - Passengers - N/A
Nature of Damage:	Aircraft destroyed
Commander's Licence:	Commercial Pilot's Licence with Flying Instructor's Rating
Commander's Age:	49 years
Commander's Flying Experience:	Approximately 7,350 hours (much of which were instructional hours on PA 28 variants) Last 90 days - 135 hours Last 28 days - 55 hours
Information Source:	AAIB Field Investigation

Background

Recoveries from fully developed spins are not required during training for the Private Pilot's Licence but they remain in the syllabus for pilots who aspire to be a flying instructor. In this accident the commander was training another pilot to become an assistant flying instructor. The trainee, a retired airline Training Captain with some 13,000 hours of flying experience, had very little recent experience of light single-engined aircraft and probably had not practised spinning for many years. At the time of the accident the weather was suitable for spinning; the cloud structure was two octas base 3,000 feet and the visibility was 2.3 kilometres.

History of the flight

The club-owned aircraft took off from Royal Air Force Woodvale at 1206 hrs and changed frequency to Warton Approach for a Flight Information Service whilst carrying out general handling exercises. About 15 minutes after take off the instructor informed ATC that "WE'RE JUST LEAVING TWO THOUSAND FEET NOW... WE'D LIKE TO CLIMB TO FIVE SIX FOR SOME SPINNING FOR THE NEXT FIVE OR TEN MINUTES IN MORE OR LESS THE POSITION WE ARE IN NOW". Some five minutes later the instructor reported that the aircraft was climbing through 4,000 feet on the QNH and that the base height for the spinning exercise would be 3,000 feet. ATC replied with traffic information and the instructor's acknowledgement was the last coherent transmission received from the aircraft.

At about 1240 hrs a witness being driven in a car near Southport beach saw a white coloured aircraft spinning - she thought to the right - through several rotations before it hit the water, still spinning. From the beach the witness and her husband could see a white coloured object floating in the water but they were unsure whether this was the same object they had seen spinning. Because model aircraft are often flown from the beach, there had been no smoke and no visible markings, and there were other people on the beach who were apparently uninterested in the floating object, they concluded that the object was a model aircraft. It was not until later when she saw a news report of the crash that she reported her sighting to the police.

Radar data analysis

Recorded radar data for the last few minutes of flight were obtained and analysed by the AAIB. The early data points showed the aircraft circling to the west of Southport at an airspeed of about 82 kt which is consistent with the normal climb speed of 83 mph. The aircraft's transponder altitude code was corrupted and it was not possible to determine accurately the aircraft's vertical profile. Nevertheless, by correlating the data with the commander's altitude reports it was deduced that the aircraft climbed at a rate of about 400 ft per minute from 2000 feet altitude for up to 13 minutes giving a probable spin entry altitude of at least 6,000 feet. At 12:36:56 hrs the aircraft entered a manoeuvre consistent with a spin or spiral dive and the final radar return was recorded 62 seconds later. At about this time the Warton Approach controller also noticed the aircraft enter a manoeuvre which rendered the aircraft almost stationary on the display, a manoeuvre he knew to be consistent with a spin.

At 12:38:08 hrs (10 seconds after the final radar return) an unusual sound was recorded on the Warton Approach Frequency. Spectral analysis of the sound indicated that it was a complex sound of about 2.5 kHz pitch and 2 seconds duration which was most probably transmitted from the accident aircraft.

Search and Rescue

Although the aircraft was receiving only a Flight Information Service from Warton Approach, the Controller soon realised that the aircraft had disappeared from his radar display. He attempted to contact the aircraft by RTF at 1243 hrs but there was no reply so at 1247 hrs he asked another aircraft on his frequency to search the area where he had last seen the aircraft (which was close to the position where the aircraft was eventually found). This aircraft saw no sign of wreckage on the surface. The controller then instigated a check with local airfields which proved negative. The Lancashire Police Force Helicopter joined in the search at about 1300 hrs and was vectored to the area where the aircraft had last been seen but there was no sign of the PA28. Another helicopter from Blackpool joined the search and later still two RAF Search and Rescue helicopters joined in; during this process the sea search area was expanded to the north and south of Warton's extended

Runway 26 centreline. One RAF aircraft detected an Emergency Locator Beacon (ELB) with its specialised equipment and homed to the signal. The beacon was traced to the vicinity of Blackpool Airport. Surface-based assets including elements of the Coastguard and the Sefton District Council rescue services also joined the search.

The sea bed at Southport is sandy and shelves very gently leaving a beach about two miles wide at low water. Tidal currents disturb and carry the fine sand leaving the water brown and turbid in appearance.

On the day there were spring tides with a range of 25.6 feet between high and low water. High water occurred at 0925 hrs and low water at 1600 hrs. When the aircraft crashed into the sea the tide was ebbing and it would reduce by another 12 feet before low water. At 1440 hrs the wreckage was sighted by the lifeboat when the main wheels were seen protruding from the water; at this stage the water was about five feet deep. The wreckage was less than one quarter of a mile from the last recorded radar position.

Wreckage Recovery

Aerial photographs taken before the occupants were recovered showed sand being swept along beside the wreckage and the vertical visibility through the water was less than one foot. At this stage the aircraft was inverted and the visible portions of the underside of the fuselage, wings and stabilator appeared intact. Consequently, it is unlikely that any significant debris was liberated from the aircraft during water impact. Moreover, any floating debris would have been carried away by the tidal currents and the sunken wreckage would have been invisible until the water depth reduced from the entry depth of about 17 feet to 6 feet or less. It is not known for how long the aircraft floated but its proximity to the final radar position indicates that it could not have floated for very long.

To right the aircraft the lifeboat crew attached a strong rope to one of the main gear legs and towed it diagonally so as to pivot the aircraft around its tail and wing tip which probably dug into the sea bed. This tactic was successful but the aircraft structure was disrupted in the process. The occupants were cut free from their harnesses and recovered to the shore. Later a post-mortem revealed that neither occupant suffered from any medical condition which was likely to have contributed to any pre-impact incapacitation. However, the impact injuries probably concussed the instructor and incapacitated the trainee.

An attempt was made to recover the wreckage on the day following the accident but the effort was hampered by the very brief 'window' available at low tide to enable suitable vehicles to be deployed. Lying in a minimum of about five feet of water at low tide, it became apparent that even more damage had been inflicted on the aircraft due to wave action such that the fuselage was completely disrupted and the vertical fin and rudder could just be discerned folded against the left wing trailing edge.

The first recovery attempt failed but major portions of the aircraft were subsequently recovered by the local lifeboat crew a few days later. These comprised the engine, propeller and firewall, wings and cabin floor, the lower half of the rear fuselage and the stabilator. The fin, rudder, instrument panel and majority of the fuselage were not recovered.

Examination of the Wreckage

Although a substantial amount of the wreckage was missing, much of the flying control runs were present apart from the control yokes and mechanism behind the missing instrument panel. It was possible to determine that the rudder and stabilator cables had not suffered any pre-impact disconnection. The stabilator trim cable drum was found to be on the fully nose-up stop, almost certainly due to differential pulling on the cables as the aircraft broke up. As found, the flap lever was in the first extended detent, which should clearly not be the case given the nature of the pilots' intentions. However, the flap mechanism was still free to articulate and it was possible to move the flap lever from UP towards the extended positions with virtually normal action. Thus there was no way to determine conclusively whether the flap lever had been moved during or after impact as no witness marks were found on the flap surfaces themselves which could indicate a particular pre-impact position.

The two front seats were recovered, one still attached to one of its rails. The locating pin was found in the extreme forward detent with no signs of having broken-out of any other position. It is difficult to accept that this was a pre-impact location of the seat as it would be difficult for anyone of average build to operate the aircraft in such a cramped seating position. Had the seat inadvertently moved forward during the aircraft's manoeuvring, then the occupant would have been restrained by his seat harness. In the case of the other seat, which was found separate from its rails, it was not possible to ascertain which position it had been in, neither was it possible to determine which (left or right) location either seat had occupied in the aircraft.

In summary, the examination of the wreckage available did not reveal any obvious reason for the aircraft's failure to recover from the intentional spin. The general condition of the structure, particularly as evident from the aerial photographs before major disruption occurred, was consistent with entry into the water in a relatively flat, upright, attitude and moderate rate of descent with almost no forward speed. The condition of the propeller also suggested that little, if any, engine power was present.

G-BBLA's Spin Behaviour

The aircraft was acquired in 1978 by the previous owners of the flying club. The CFI at the time, who remained in post until 1985, informed the AAIB that from the time the aircraft was acquired, compared with two other PA28-140 aircraft belonging to the club, G-BBLA had always exhibited a tendency to spin with an unusually nose-up pitch attitude. No reason for this idiosyncratic behaviour was identified and the club preferred to use other aircraft for spin training.

The commander and the club's deputy chief engineer (who held a PPL) were also aware of G-BBLA's unusual spin characteristics but the aircraft had not previously shown any extreme reluctance to recover from a spin. However, a few days before the accident the commander told the deputy chief engineer that he had attempted to enter a spin but the aircraft would not **enter** a spin in either direction. The engineer offered to investigate this problem but the commander decided that it was unnecessary.

In his personal folder for briefing students, the commander had notes on spinning technique which for spin entry recommended closing the throttle as if practising a stall and then applying full rudder and easing the stick fully back at a speed of 60 to 65 mph. A photocopy of this page was found on a desk in the club's classroom; the original speeds had been amended by hand to read 65 to 70 mph. There was only one student at the club who was undergoing spin training at the time and so it seems likely that the commander briefed the student that they would attempt to induce the aircraft to spin by raising the entry speed.

According to the club records and his own logbook, before the accident spin the commander had not spun G-BBLA since its Certificate of Airworthiness Flight Test, flown by him, reportedly on 10 September 1995. During this test he recorded 'SATIS' in the check boxes labelled 'Any abnormality of spin or recovery' during spins in both directions and the aircraft recovered after one and half turns.

Although he had not practised spinning in the PA28-140 since September 1995, the commander had practised spinning a Chipmunk as recently as 15 August 1996. He was unable to spin the club Chipmunk after 15 August because the club sold it on that day leaving it with only PA28-140 aircraft in which to practice spinning. The spin recovery technique in the commander's briefing notes followed the procedure common to most light aircraft types. Essentially the technique was: check throttle closed; full opposite rudder; pause; ease stick forward until spin stops and then centralise the controls before easing out of the ensuing dive.

Spinning the PA28-140

The Manufacturer's Flight Manual for G-BBLA dated 27 April 1973 stated that the aircraft may be intentionally spun provided that the weight and balance are within permitted limits.

The two pages in the Flight Manual allocated to 'Handling' made no mention of spin entry or recovery techniques. In 1982 the Piper Aircraft Corporation issued Service Bulletin (SB) No 753 whose purpose was as follows (quoted verbatim):

To provide expanded spin recovery procedures to assure that proper safety practices and procedures relative to utility category flight operations are in effect. Spin training is permitted only in the utility category.

Accompanying this Service Bulletin is an expanded information placard to be installed in the cockpit in full view of the pilot. This Service Bulletin is to be retained at all times in the airplane with the aircraft paperwork.

There was no record of embodiment of this SB in the G-BBLA's logbooks. The SB re-iterated the utility category weight and balance limitations, described the need to take account of individual seat positions on the seat tracks, and itemised the manufacturer's recommended spin recovery technique. In this technique the handling of the control column in pitch was materially different to that contained in the commander's notes. The SB stated the procedure as follows:

1. Apply and maintain full rudder opposite the direction of rotation.
2. As the rudder hits the stop, rapidly move the control wheel full forward and be ready to relax the forward pressure when the spin rotation has stopped.
3. As rotation stops, neutralize the rudder and smoothly recover from this dive.

Notes within the SB included the following statements:

In all spin recoveries the control column should be moved full forward briskly. This is vitally important because the steep spin attitude may inhibit pilots from moving the control column forward positively.

Delay in moving the control wheel forward may result in the aircraft suddenly entering a very fast, steep spin mode which could disorient a pilot. Recovery will be achieved by briskly moving the control wheel fully forward and holding it there while maintaining full recovery rudder.

Aircraft weight and balance

Being unaware of the refined limits in SB753, the commander should have assessed the aircraft's weight and balance relative to the Flight Manual data which specified a nominal seat position of 85.5 inches aft of datum. Calculations made following the accident suggested that, using the aircraft's weight and centre of gravity schedule dated 3 September 1992; the limits in the Flight Manual; the estimated fuel load of 8.3 Imperial gallons; and with these seats in their nominal positions, the centre of gravity would have been 0.5 inches forward of the forward limit for aerobatics at the time of the accident.

The AAIB then obtained accurate weights and leg lengths for both pilots and assessed the likely seat positions they would have adopted before practising spinning. These data were then used to re-calculate the CG position using the seat position moment arms contained in SB753. The calculations showed that the CG during the spin was probably 0.2 inches forward of the forward limit.

The New Piper Aircraft company were asked if they could provide any likely reasons why the aircraft might be reluctant to recover from a spin. Their suggestions were helpful but not applicable to GBBLA.

Safety recommendations

During the investigation it transpired that few PA28-140 operators used the type for spin training but many were unaware of the content of SB753. Therefore it was recommended that:

97-5 The CAA should bring to the attention of UK owners and operators of the PA28-140 the existence and content of Piper Service Bulletin No 753.

97-6 The CAA should make mandatory any manufacturer's Service Bulletin which addresses important aspects of aircraft flying qualities or handling techniques.

97-7 The FAA should require the Piper Aircraft Company to re-issue the content of Service Bulletin 753 as an official supplement to the PA28-140 Flight Manual.