

Air Command 532 Elite, G-BOVP, 20 April 1996

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Aircraft Type and Registration:Air Command 532 Elite, G-BOVP

No & Type of Engines:1 Rotax 532 piston engine

Year of Manufacture:1989

Date & Time (UTC):20 April 1996 at about 1455 hrs

Location:Long Marston Airfield, Warwickshire

Type of Flight:Private

Persons on Board:Crew - 1 Passengers - none

Injuries:Crew - 1 fatal Passengers - N/A

Nature of Damage:Aircraft destroyed

Commander's Licence:Private Pilot's Licence (Gyroplanes)

Private Pilot's Licence (Aeroplanes)

Commander's Age:64 years

Commander's Flying Experience:646 hours (of which 40 were on gyroplanes)

Last 90 days - 5 hours (2:30 on gyroplanes)

Last 28 days - 3 hours (2:30 on gyroplanes)

Information Source:Field Investigation

History of flight

The pilot was taking part in a gyroplane rally at Long Marston Airfield. He arrived at about 1400 hrs with the gyroplane on a trailer; with the assistance of another participant he unloaded it and fitted the rotor blades. The engine started after about six pulls and was run briefly to check that it was functioning correctly. Some time later, probably at about 1430 hrs, the gyroplane took off from grass runway 20 and was seen to climb to about 1,000 feet agl and head north, towards Stratford-upon-Avon.

The gyroplane returned some 20 minutes later, heading south, at a height variously estimated as between 1,000 and 2,000 feet agl; the wind at 2,000 feet was about 220°/15kt. It was reported to

have been flying slowly when it entered a right turn which continued through 360° back to the starting point. It was then that observers noticed that the rotor appeared to be turning very slowly; it was possible to discern the individual blades. The subsequent manoeuvre was variously described but the gyroplane appears to have descended, rotated to the right for 2 or 3 turns and then tumbled to an almost inverted attitude. A witness from a group flying model aircraft heard a "metallic bang"; this was also described by another as "like a starting pistol". He saw the gyroplane tilt initially about 45° to the right and as it fell, the tilt appeared to increase to 90°; it was difficult to determine precisely when the bang occurred but the witness thought it may have been at the point of, or shortly after the initial tilt to the right. A flying instructor who had just taken off in a microlight saw the gyroplane pass on his right side, going vertically downward in an almost inverted but stable attitude with the rotor blades bent upwards towards the body; he was climbing through about 400 to 500 feet at the time. The gyroplane struck the asphalt perimeter track in the south west corner of the airfield.

The pilot held a current class 3 medical with the limitation that the holder must wear spectacles which correct for near/distant vision; he wore suitable contact lenses. The pilot's medical records and post mortem examination revealed no pre-existing medical condition which would have contributed to the accident. He wore a motor cycle type crash helmet, however, the severity and attitude of the impact were such that it would have had no effect on the outcome of the accident, in which he died instantly.

The pilot started flying in 1953 with a University Air Squadron and by 1956 he had flown 135 hours in the Chipmunk. His next recorded flying was in May 1974, and he gained a PPL (Aeroplanes) in July 1975. He started training to fly gyroplanes, at Coventry, in August 1988; from May 1990, the training was done in G-BOVP and he gained a PPL (Gyroplanes) in August 1990. By October that year he had flown a total of 36 hours in gyroplanes. His flying was then exclusively in fixed wing aircraft until November 1995 when he again flew G-BOVP for 1:30 hours. No further flights on gyroplanes were recorded until 3 April 1996, 1:00 hour and 6 April 1996, 1:30 hours; all his gyroplane flying was on the Air Command and the flight on 6 April was the last recorded flight on any type before the accident.

The aircraft's logbook was not recovered, but the documentation held by the PFA indicated that the modifications required under Airworthiness Approval notice PFA-G/04-325 to regain the Permit to Fly - revoked in 1991 as a result of earlier accidents - were embodied. A flight test had been completed by 13 September 1995. One of these modifications was the installation of horizontal stabilisers added to the all moving rudder. The Permit was granted on 18 October 1995. The hours counter on the instrument panel recorded 24.1 hours.

The accident site comprised an area of old tarmac with a new 3.3m wide tarmac road passing through it. The gyroplane had descended almost vertically into the road, and most of the wreckage was contained within a 7m square; the furthest piece of debris found was a tubular section of landing gear structure 10m from the primary impact point. At impact with the ground the gyroplane had a roll angle

of approximately 120° to the right, and was slightly nose high. The first impact was probably on the rotor blade advancing from the fore-and aft position, the right side of the engine, nacelle and landing gear then took the brunt of the impact. There was a heavy impact mark on the ground from the leading edge of one blade (the rotor revolves anticlockwise when viewed from above), and both blades were bent and delaminated. An examination by a materials laboratory confirmed that the joints between the upper and lower halves of the rotor blades had been satisfactory; it was therefore

concluded that the rotor blades had delaminated on impact. There had not been any impact by the rotor on the rudder or propeller.

The throttle was found in the closed position, the fuel was on and the filter/sight glass was full. The propeller and final drive had separated from reduction gearbox, but only two propeller blades were damaged - by lengthwise splitting on one leading and one trailing edge consistent with hitting the ground at low RPM. An engine strip did not reveal any pre-impact damage.

The right stabiliser was found to be broken in several pieces consistent with a ground impact. The two extruded light alloy brackets attaching the stabiliser to the rudder had failed in the right angle of the extrusion. Metallurgical examination of the failed brackets which had attached the right stabiliser to the rudder showed that they had failed in a single application of overload; this indicated that the stabiliser had been in place at impact. A strut, formed from a light alloy tube flattened at both ends to accommodate a bolt, was used to brace each stabiliser. The right strut was still attached to the base of the rudder, but the upper end had become detached from the right stabiliser, and although the bolt was missing, there was minimal damage to the bolt hole.



Photograph showing the rudder and right stabiliser bracing strut

This discrepancy was identified on receipt of the wreckage at Farnborough, and the bolt was found, loose *and without a nut*, amongst the debris collected from the site. Comparisons of lengths and gel coat traces confirmed that it had come from the right stabiliser. The bolt was 2BA and was worn and rusty, but otherwise undamaged. When the significance of the missing nut was realised, the accident site was searched again, this time using a sensitive metal detector, however the nut was not found.

Damage to the lower skin of the right stabiliser indicated that the bolt was still in place at impact - an area of the Glass-Reinforced Plastic (GRP) located under the strut end had been pushed through into the backing foam, and the displaced section of GRP contained a witness mark showing the outline of the strut end in the black paint used on the strut. However, the end of the strut

around the bolt hole showed insufficient signs of distress to account for the loss of the nut during the ground impact (see above photograph).



The length of the bolt (2BA) fastening the strut onto the left stabiliser was excessive, and extra washers were packed under the nut to prevent it bottoming on the unthreaded portion of the shank. The nut fitted to this bolt was cadmium plated, but two of the four lock nuts used on the 'L' shaped brackets between the rudder and the stabiliser were rusty. The source of the used nuts and bolts in this area was not established, but the modification kit containing the stabiliser was supplied with new (UNF) nuts and bolts, and these had reportedly been used in the original installation of the kit. The documentation covering the inspection of the aircraft before its test flight confirmed that the stabilisers had been *'properly installed and inspected'*. The 2BA bolts are a British design and would not be supplied with a kit assembled in the USA. The type and condition of the missing nut was not known, but it was noted that a plain (ie not self locking) UNF nut with 32 threads per inch (tpi) could be fitted to both 2BA bolts (31.4 tpi) recovered from the stabilisers, but that they made a very loose fit and could be spun off easily.

The AAIB were informed that shortly after the aircraft regained its Permit to Fly it suffered a heavy, tail wheel first, landing. This caused damage to the mast and to the rudder pivot block, and during the repair the aircraft was dismantled and repaired by its owner. The dismantling involved the removal and refitting of the mast, rudder and tailplanes.

Other Accidents

Components which had exhibited characteristic witness marks on other crashed Air Commands were examined on VP:

In most accidents involving low rotor rpm the rotor has either struck the rudder of the propeller. This has been ascribed to a sudden upset in the balance of moments about the centre of gravity (cg) between the propeller and rotor thrust. If the rotor is suddenly off loaded the resultant out of balance

couple caused by the propeller thrust acting about the cg can cause a self sustaining, irreversible forward buntover during which the gyroplane tailrotates upwards into the rotor at a faster rate than the rotor can precess in the same direction.

There was no rotor strike in this accident. However, there appears to have been a period when the gyroplane was neither completely under control nor out of control, but the rotor did appear to be slowing. If the throttle was closed at this point, the effect of the couple would have been significantly reduced and with no other influence the nose would have pitched up slightly.

The washer under the rotor head retaining bolt had exhibited fretting or concavity in the past. On VP this washer had been replaced with a steel washer as specified by the additional inspection requirements issued by the PFA.

Wear had been noticed on the shank of the rotor head retaining bolt. On VP the bolt had bent during impact, this had the effect of increasing the clamping force and had consequently tightened the assembly. However, at some points the bolt shank had lost its cadmium plating and showed some signs of polishing. In view of the work carried out after the heavy landing, it could not be determined whether this wear was caused by the build state immediately prior to the accident.

Witness marks had been observed on the bell housing of the drive unit caused by the teeth on the ring gear. On VP the top of the bell housing showed a light circumferential rub, covered by grease. The rub had removed the cadmium plating, but there was no sign of any deeper mechanical erosion.