Lockheed P-38J Lightning, N3145X

AAIB Bulletin No: 5/97 Ref: EW/C96/7/4Category: 1.1

Aircraft Type and Registration: Lockheed P-38J Lightning, N3145X

No & Type of Engines: 2 Allison V-1710 (1,425 hp) piston engines

Year of Manufacture: 1943 (Rebuilt 1992)

Date & Time (UTC): 14 July 1996 at 1451 hrs

Location: Duxford Airfield, Cambridgeshire

Type of Flight: Aerial Work (Flying Display)

Persons on Board: Crew - 1 - Passengers - None

Injuries: Crew - Fatal - Passengers - N/A

Nature of Damage: Aircraft destroyed

Commander's Licence: Airline Transport Pilot's Licence

Commander's Age: 54 years

Commander's Flying Experience: 14,500 hours (of which 60 were on type)

Last 90 days - 11 hours on type

Last 28 days - 5 hours on type

Information Source: AAIB Field Investigation

The aircraft was performing at the 'Flying Legends' Air Displayat Duxford, which was being staged over the two days of the weekendof 13/14 July 1996. The display on 13 July was completed withoutincident. On 14 July, the aircraft had taken off at 1435 hrsas the lead aircraft in a formation comprising one Curtiss P-40BTomahawk and one Bell P-63 King Cobra fighter aircraft. The display'slot' commenced at 1439 hrs and after several formation passesin front of the assembly of spectators, the trio split up in orderto enable each aircraft to carry out a solo display. The P-38was the final aircraft to perform its solo routine and was dueto clear the display area by 1455 hrs. The aircraft commencedits run in from the east of the airfield, in a shallow dive togain speed, then carried out a loop. This manoeuvre was followedby a 'Cuban Eight' manoeuvre, which involved two short periodsof flight under negative 'g'. As the aircraft returned to normalpositive 'g' flight after each of these periods, a slight trailof light coloured vapour was noted coming from under the mainbody of the aircraft (post-accident consideration of the aircraftsystems concluded that this was most likely to have been vapourescaping from the fuel tank vent lines).

At the end of the 'Cuban Eight', the aircraft was passing fromeast to west (crowd left to right). It pulled up and to the leftinitially, levelled the wings, then performed a 270° rollto the left. The aircraft then came back to pass acrossthe front of the crowd from west to east.

With the aircraft appearing to be at a normal entry height andspeed, an aileron roll to the left was commenced as the aircraftcrossed the western threshold of the hard surfaced Runway 06. The first 360° roll was completed apparently normally butthe aircraft continued, without pause, into a second full roll. While the aircraft was inverted in this second roll, the nosepitched towards the ground and the aircraft began to lose heightwhile the roll continued. By the time the aircraft became uprightagain, it had descended to a very low height above the runway. The aircraft continued to roll left and struck the runway withits left wing, with some 30° of left bank applied, abouttwo thirds of the way along Runway 06.

The left outer wing ruptured and collapsed, followed by an impactof the left engine. At this time, a large fireball erupted asthe aircraft began to cartwheel across the airfield, breakingup into multiple fragments as its trajectory took it diagonallyaway from the main spectator area towards a row of parked lightaircraft on the south side of the airfield. Several of theseaircraft were destroyed or severely damaged in the wreckage'spath. One of the engines bounced further than the rest of thewreckage, crossing the airfield boundary and then the M11 Motorwaywhich runs almost perpendicular to the end of the runway. A passingfreight truck sustained some minor damage from pieces of wreckagebut was able to continue travelling northwards along the motorway. The engine came to rest in a field just to the east side of themotorway, close to where several members of the public had beenstanding in order to watch the flying activities from outsidethe airfield boundary.

The airfield Fire and Rescue services were quickly at the sceneand brought the numerous areas of fire under control in a shorttime. The pilot was found in the seat, with his four point harnessstill fastened, amongst the wreckage of the main fuselage pod. A post-mortem examination found that the pilot had been killedby a severe head injury. No physical condition was found whichcould have caused any incapacitation of the pilot and no tracesof drugs nor alcohol were found to be present. It was assessed that the destruction of the cockpit was such that survival wasimpossible.

The pilots and passengers of the visiting light aircraft had been required, by the airport operator, to move to the spectator side of the runway in order to watch the air display. Fortunately, there were no injuries to any spectators.

The display routine followed by the P-38 formation was identical to that flown at the display on the day prior to the accident. The significant difference was that during the Saturday display, only a single 360° aileron roll had been carried out, but the time of the accident two consecutive 360° rolls hadoccurred, with a continuation past the wings level at the end of the second roll.

Soon after the accident, the air display organisers made an announcementover the public address system for any spectators who had photographed, or taken video footage of, the final manoeuvre to hand in theirfilms/tapes on loan for the purposes of this investigation. Anexcellent response was forthcoming, which resulted in AAIB havingaccess to some 60 video tapes and 40 sets of photographs of theevent.

The weather at the time was a surface wind from 270° at 6kt, variable in direction between 240° and 300°, visibilityin excess of 10 km, scattered cloud base 3,000 feet, QNH 1026mb.

Video Analysis (Figure 1)

Photographs and video coverage of the aircraft's manoeuvres were analysed with a view to assessing not only the pre-impact flightpath characteristics but also the pre-impact aircraft integrity and the operation of aircraft systems. A full flight path analysis was carried out using several video sequences which had been filmed from a variety of viewpoints.

A recording was available of the Saturday display, where one aileronroll to the left was performed. The time taken to complete theroll on this occasion was 3.4 seconds and it was noted that the aircraft had an upward trajectory throughout this manoeuvre.

The analysis of the accident coverage showed that the aircrafthad performed two continuous aileron rolls, taking 4.4 seconds and 3.6 seconds respectively to complete. This had been started a height of about 250 feet above the runway, at a speed of about 250 knots and with an initial nose-up pitch attitude. The roll, to the left, was initiated by a rapid roll controlinput to produce a considerable aileron deflection. This ailerondeflection remained more or less constant until the aircraft hadcompleted about 675° of roll. At that point, the aileronswere returned to the neutral position where they remained until the aircraft struck the ground.

During the first roll the aircraft climbed to an apogee of about360 feet when inverted, descending to about 260 feet by the timeit was erect again. At this point the aircraft pitch attitudewas approximately horizontal or very slightly nose-down. Therewas no pause before the second roll was executed. During thisroll, the nose dropped progressively and an increasing rate ofdescent built up. At the inverted position the aileron positionwas observed to be being maintained in the almost fully (leftroll) deflected position and a considerable elevator displacement in the 'stick back' sense was made. Considerable left ruddercontrol was also added at this time and the roll rate increased. About 45° of roll before the aircraft became erect, therudder and aileron inputs were moved to neutral, but were notapplied in opposition to the roll. The rate of roll was seento increase slightly as the aircraft rolled through wings level(from about 110°/sec to 125°/sec), with a rate of descentof about 7,200 feet per minute, to the point of impact. Groundspeed at impact was assessed as 230 kt. The final angle of descentwas 14.5°, giving a speed along the flight path of 238 kt.

Impact was seen to occur on the left wing tip at an attitude of about 30° left roll with the fuselage level in pitch. Theaileron and rudder positions were approximately neutral and theelevator was deflected up.

An analysis of the propeller speeds from video showed that theyremained constant throughout the rolling manoeuvre. Both propellerswere turning at about 1,300 RPM, the right slightly faster thanthe left. With the engine propeller reduction gearing ratio of 2:1, this accorded with the aircraft operating limitations whichquoted the engine limits for use in aerobatic manoeuvres as 2,600RPM/40 inches manifold pressure.

It was also noted on the video coverage that the coolant radiatorexit flaps were not symmetric for each engine. Those for theleft engine were noted to be fully open, while those for the rightengine were in trail, for a large part of the final display sequence. Correct engine operation during the manoeuvres was assessed byother means and any possible effect of the asymmetry on the handling of the aircraft was not considered to be significant.

Engineering Investigation

The aircraft had struck Runway 06, straddling the centreline and about 450 metres short of the eastern end. The initial impacthed been of the left wingtip on the runway and the sequence of marks

of the immediately subsequent impacts was consistent withthe aircraft being on a heading of about 079°M (the runwayheading is 062°M), in a substantially level pitch attitudeand significantly banked to the left. Examination of the cutsmade by both propellers in the runway surface indicated that bothengines were developing considerable power and that the aircrafthad a high rate of descent. Initial assessment of the propellermarks, without making allowances for rate of descent, indicated that the aircraft had struck the ground with engine speeds of the order of 2500 RPM associated with a ground speed of about 200 kt.

After the initial impact, the left outer wing, empennage and bothtailbooms separated from the remainder of the airframe which yawedsharply to the left before crossing the southern edge of the runwayand cartwheeling across the grass. The main wreckage came torest, inverted, in a wheat field, about 420 metres from the pointof initial impact, just outside the southern boundary of the airfield. Both engines became detached from their mountings after impact; the right had been thrown 60 metres beyond where the main wreckagecame to rest and the left 180 metres beyond, crossing the M11Motorway. Although the aircraft had burst into flames very shortlyafter the initial impact, there was little evidence of substantialfuel spillage between the point of initial impact and where themain wreckage came to rest, there being only isolated areas ofblackened grass. There was, however, evidence of a moderatelysevere ground fire around the main wreckage and a considerablearea of the wheat field, generally to the south (right) of anextension of the line between the initial impact and the mainwreckage, had been burnt.

The wreckage was removed to the AAIB facility at Farnborough formore detailed examination.

This revealed no evidence of any pre impact structural distressof the airframe nor loss of attachment of control surfaces. Therewas no evidence of pre-impact loss of integrity of the controlsystems, all damage being consistent with the nature and degree of structural break-up after impact. The extent of the disruption to the control systems precluded eliminating the possibility of any transient obstruction of the systems. Assessment of the scrapemarks on the left outer wing and aileron, made during the initial contact on the runway, showed that the aileron had been at a substantially neutral position at that moment. Damage on the left end rib of the elevator and on the closing rib at the left end of the tailplane cut-out indicated that the elevator had been deflected up at the time the left fin base struck the runway. The impact positions of both ailerons and elevator surfaces were confirmed by the videoanalysis.

The aileron boosters were examined. The position of the by-passcontrol piston of the left booster showed that, when it becamedisrupted at the time of impact, hydraulic pressure had been available. Damage to the input rod of its control valve indicated that therehad been no aileron movement demand at that time and damage tothe output rod of the actuating cylinder was consistent with itsbeing at a neutral position. All damage to the left and rightbooster assemblies was consistent with the damage to the structureto which they were attached and there was no evidence of any pre-impactfailures.

The blade pitch change mechanisms both propellers were examined; the initial dismantling being performed with the assistance of the operator's maintenance organisation. This revealed no evidence of malfunction nor damage inconsistent with that sustained as a result of impact. It was not possible, from examination of the pitch control gear quadrants from the blade roots, to establishexact blade pitch settings at impact. However, impact damageto the teeth of the quadrant gears indicated, on balance, that both propellers had been working within their governed pitch rangeand consequently at selected speed. It was not possible to determine the selected speed from the engine mounted governors.

Pilot's Flying Experience and Documentation

The pilot held an Airline Transport Pilot's Licence and was typerated on Boeing 737 series, Boeing 757/767 and Piper PA-23/34/44series aircraft. He was a Captain with a UK charter airline flyingBoeing 757 and 767 aircraft and was the Chief Pilot for the operator of the P-38, responsible for the crewing and operation of a variedfleet of some 15 vintage 'warbird' aircraft types.

The pilot was also the Air Show Display Co-ordinator for the 'FlyingLegends' display at Duxford, being responsible for the planning the display items and for the choreography of the show finale, which also involved leading a mass flypast of some 40 historicaircraft. He gave the daily display briefing to the participating pilots and undertook some in-show replanning on the Sunday afternoonwhen the planned show sequence was interrupted by the arrivalof a significant display item almost an hour ahead of the plannedschedule. This undoubtedly added to the pilot's workload forthe afternoon. Shortly after this, the pilot participated in the show in the lead aircraft of a pair of DH89A Dragon Rapides. After landing from this, there was then some 12 minutes beforehe then taxied out in the P38 for the start of that displayitem.

The pilot was operating the P-38, an aircraft registered in the USA, under the privileges of his FAA Commercial Pilot's Licence. Under normal circumstances, as the aircraft maximum take-offweight was in excess of 5,700 kg (12,500 lb), a specific aircrafttype rating would be required. In this case, the pilot held aletter, issued by the FAA Flight Standards District Office in Oakland, California during 1988, which authorised him to operate pilot-in-command in experimental category aircraft - "Alltypes and makes of high performance piston-powered aircraft." The letter also noted that it did not, in itself, authorise the performance of aerobatics in airshows. A separate authorisation for this activity is required, but only in respect of participationat airshows within the USA.

The FAA indicated that the documentation held by the pilot didcomply with the appropriate US Federal Aviation Regulations and the special operating limitations for the aircraft duringthis flight. However, the FAA did note that since the issue of the letter of authority, the procedures had since been changed to reflect current requirements, but the letter remained valid.

A Biennial Flight Review certification (to validate the FAA licence)was entered in the pilot's flying log book by an FAA CertificatedFlight Instructor on 16 July 1995.

The pilot held a CAA Display Authorisation (DA) covering manyaircraft types including the P-38. He also held an appointmentas a Display Authorisation Evaluator on behalf of the CAA.

The pilot's DA had a current validation and permitted the performanceof flypasts down to 30 feet agl and aerobatic manoeuvres (in certaintypes) down to 100 feet agl. For the P-38, the minimum aerobaticheight was specified as 200 feet agl. Formation flyingwas also permitted.

From the video evidence available, it was apparent that the pilotcommenced the final rolling manoeuvre at a height which was inaccordance with his DA.

On the Saturday, the day prior to the accident, the pilot flewa similar display profile but with only one aileron roll at crowdcentre. Some minor transgressions of the pilot's DA limitationswere noted by the attending CAA Air Display Inspector, notablyin terms of the minimum aerobatic height during the aileron rolland for being marginally inside the minimum lateral separation distance appropriate for aerobatics. Both of these comments were made by the Inspector to the pilot after the

event and the pilotgave assurance that the Sunday display would fully conform to the DA limitations.

The pilot had conducted a display practice in the P-38 on 11 Julyand had flown in the public display on 13 July. In the 28 dayperiod prior to the accident, the pilot had also flown each ofthe following types: Boeing 757, Spitfire V, Hellcat, Skyraider, Bearcat, Rapide, Aztec, Baron and Cub.

Aircraft History and Documentation

The aircraft was manufactured during 1943 at the Lockheed AircraftFactory in Burbank, California and had the serial number 42-67543. It operated in service with the United States Army Air Forceuntil being discharged in February 1945. It was found by itscurrent owner in a derelict state in Texas in 1988. After purchase, it was taken to California and restored to flying condition. Test flying was carried out early in 1992 and the aircraft wasimported into the UK during the summer of that year. Since then, the aircraft has operated under a CAA Exemption to the Air NavigationOrder which permitted the aircraft to fly without a valid Certificateof Airworthiness for the purposes of Demonstration and Exhibitionflying only, provided that the FAA Special Airworthiness Certificateand Operating Limitations dated 9 January 1992 were current.

The FAA Special Airworthiness Certificate was issued in January1992 in the Experimental category, for the purposes of Exhibitionflying and was current at the time of the accident. The aircraftwas being operated in accordance with the Operating Limitationsdocument. The aircraft's maintenance documents showed that ithad been correctly maintained in accordance with the FAA requirements and had been properly certified by an FAA approved licensed engineer. The FAA Certificate of Registration was issued on 21 February1992 to an owner with an address in Las Vegas, Nevada.

The aircraft was also subject to an exemption issued by the CAAin order to allow it to operate at speeds greater than 250 ktwhile below 10,000 feet. A current Aerial Work Operating Permitfor the aircraft had also been issued by the Department of Transport.

The pilot had compiled a set of aircraft operating notes for the P-38, which indicated that, for aerobatics, the engine limitswere 2,600 RPM and 40 inches manifold pressure (the maximum continuouspower setting for the aircraft), the entry speed for rolling manoeuvreswas 200 kt and that no negative 'g' manoeuvres were permitted because of possible hydraulic problems. It was ascertained that a previous occurrence of negative 'g' had caused a hydraulic aeration problem which prevented the landing gear down function, which required manual hand pump operation to recover. It was also indicated that the preferred rolling direction was to the left in order to prevent the unlocking of the nose landing gear door mechanism, which was known to have occurred during previous rolls to the right. These hydraulic problems were not known to have caused any adverse effects in the aileron booster systems.

Information from the aircraft's Maintenance Instruction Manualstates that with aileron hydraulic boosters operating, the pilot'scontrol input applies one sixth of the total aileron load. Theimplication of this is that, in the event of a failure of thehydraulic booster system, the aileron control forces felt by thepilot would be six times greater than normal for a given ailerondeflection under the same flight conditions. From examination of the aileron booster system, it is considered that, in the event of a hydraulic failure while the ailerons were deflected duringthe rolling manoeuvre, the aileron deflection would have tended to reduce as a result of the aerodynamic forces.

Copies of the original 1944 Pilot's Flight Operating Instructionsfor this type of aircraft were also available. These contained the following relevant extracts:

"AILERON CONTROL HYDRAULIC BOOSTER - ...On these airplanesmost of the aileron control force is provided by hydraulic boost; the remainder is applied by the pilot....Control cables whichcontrol the boost mechanism are mechanically connected to the control surfaces, allowing manual flight control in an emergency. The aileron boost shut-off valve is located on the right side of the cockpit near the pilot's control column. In addition to this valve an automatic by-pass valve is incorporated in the mechanism allow free movement of the ailerons in case the hydraulic pressureshould fail."

In the "Flight Restrictions" section, it was noted that "Snap Rolls" and continuous inverted flight were prohibited. The section also contained the cautionary note:

"Extreme care must be taken during acrobatic manoeuvreswhich require a downward vertical recovery. Acrobatics shouldnot be attempted at altitudes below 10,000 feet."

Duxford Airfield Information

Duxford airfield has a main Runway 06/24 of asphalt/concrete construction, dimensions 1,503 metres long and 45 metres wide. Additionally, to the north of this, is a parallel grass runway, 890 metres longby 30 metres wide (Figure 1). For air display purposes, the displayaxes are defined by reference to either the grass or hard runways, dependant upon the speed of the participating aircraft.

For this display, participants were briefed that the display axisfor aircraft performing at speeds up to 200 kt was the northernedge of the grass runway. The P-38 display speed was in excessof 200 kt, so it was using the northern edge of the hard surfacedrunway as its display axis, in order to comply with the minimum distance requirements laid down in CAP 403.

When detailed measurements were checked during this investigation, it was found that there were some anomalies in the display axisdistances at the western end of the airfield which did not meetthe specified minima. This situation was advised to the airfieldmanagement at Duxford by AAIB and the necessary changes were implemented in time for the subsequent public air display in September 1996. These involved the relocation of the display line (for aircraftup to 200 kt) to the southern edge of the grass runway, and themovement of the crowd line northwards by 23 metres at the westernend of the airfield.

The airfield General Flying Orders contain Annex B, Rules for Display and Demonstration Flying. The Orders contain the statement "Aerobatic manoeuvres should be flown such that they are capable of being completed by 500 feet AGL." This requirement was also stated in the daily briefing notes produced by the airfield management.

Consideration of the final rolling manoeuvre

Evidence was obtained which showed that the aircraft had successfullycompleted a double rolling manoeuvre in the past, with a significantupward trajectory apparent throughout. However, the majority of other pilots, who also flew aircraft belonging to the same operator, indicated that a single aileron roll manoeuvre was byfar the more common. This view was supported by Air Display Inspectors from the CAA.

The pilot used a metal knee-board which was usually strapped aroundhis right leg. This was found with the strap fastener undonein the debris adjacent to the main wreckage. Checks carried outon a similar aircraft in the USA found that a similar knee-boardcould, if dislodged, become jammed in the flight controls in anyof several places. The pilot also habitually carried (in hisflying suit) a 'multi-tool' and a screwdriver set with detachablebits. These were also found adjacent to the main wreckage. Therewere no significant witness marks, either on the knee-board oron the tools, to suggest that they had become jammed in the flyingcontrol mechanisms. The pilot's torch and other personal effectswere found in-situ in his flying suit.

Consideration of the flight profile (Figure 1) indicates that the start of the final manoeuvre occurred over the western end of the hard surfaced runway. At the end of the first roll, the aircraft was still in a location which was to the right (west) of the centre of the crowd. It is considered unlikely that the pilot would have intended to stop manoeuvring at this position as the display would then have appeared 'asymmetric' from the crowd's viewpoint.

It is known that the pilot was a very experienced display pilotand produced high quality, aesthetically pleasing displays. There is no evidence to explain why the aircraft entered the secondpart of the final manoeuvre in a less than optimum pitch attitudewhich developed into a significant downward trajectory. The possibility of a temporary restriction to the flying controls (especiallythe roll control), or some other form of distraction of the pilot, could not be dismissed.

Air Display Safety Review

In response to this and several other UK air display accidentswhich occurred during the 1996 display season, the CAA set upa Civil Air Display Review Group. The group identified some 18 areas for detailed investigation and comment, covering many aspects of display organisation and participation. The work of the group currently ongoing but relevant recommendations should be implemented, either by means of amendments to CAP 403 or by other means, intime for the start of the 1997 display season. There is also an intention for the CAA to develop additional guidance material for display pilots in a similar fashion to the RAF Flying DisplayNotes.

In view of the Review Group activity already being undertaken, AAIB considered that no further Safety Recommendations were necessaryin this case.