Accident

Aircraft Type and Registration:	DJI M300
No & Type of Engines:	Four electric motors
Year of Manufacture:	Unknown (Serial no: 1ZNPMCG001T035)
Date & Time (UTC):	1 June 2026 at 0323 hrs
Location:	West Bridgford, Nottinghamshire
Type of Flight:	Emergency Services Operations
Persons on Board:	Crew - None Passengers - None
Injuries:	Crew - N/A Passengers - N/A
Nature of Damage:	Damaged beyond economic repair
Commander's Licence:	Other
Commander's Age:	25 years
Commander's Flying Experience:	128 hours (of which 84 were on type) Last 90 days - 27 hours Last 28 days - 15 hours
Information Source:	Aircraft Accident Report Form submitted by the pilot and further enquiries by the AAIB

Synopsis

A DJI M300 unmanned aircraft (UA) was being operated by emergency services to search for suspects in a residential area. The motor arms had been placed in their flight positions by the remote pilot (RP) at the beginning of his shift, but there was no requirement to re-check they were secure prior to each flight. The takeoff and control checks all appeared normal, but after about four minutes, a warning occurred advising the RP to land the UA and check the security of the motor arms. Shortly after, a further series of warnings occurred, and the UA started to spin uncontrollably whilst descending rapidly from a height of about 380 ft agl before striking a residential road. No persons were injured.

Analysis by the manufacturer indicated that the rear right motor arm had folded inwards because the arm was not correctly installed. In response to this accident, the operator issued a Safety Notice (SN) that introduced mandatory pre-flight checks of the motor arm locking mechanism. The National Police Chiefs' Council (NPCC) also promulgated a SN and made two recommendations.

History of the flight

A police team were using an Autel MAX 4N and DJI M300 UA to search for suspects within a residential area in West Bridgford, Nottinghamshire. The RP reported that he had completed initial checks of both UA earlier in the day when he reported for the start of his shift. This had included placing the foldable motor arms of both UA into their flight positions. On the M300, the four arms are secured using a 'twist to lock' collar (Figure 1).

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The RP initially flew the Autel and after a 19 minute flight moved to a different takeoff and landing area (TOLA) (Figure 2) before starting to set up the Autel for a further flight. However, he then transferred to using the M300 following a request to live-stream video footage from the UA's camera system to the "top desk"; streaming video from the Autel had been less reliable. The M300 takeoff mass was 7.2 kg.

The RP stated that when he prepared the M300 he performed a visual check. A pre-flight checklist was also available, but this did not include checking that the motor arms were locked and secure.

After taking off, control checks were performed and all appeared normal, before the RP climbed the UA to a height of about 380 ft agl (115 m), where a 360° check for aerial hazards was performed. The RP also confirmed that the UAS handheld controller showed no warnings or error messages, before continuing the search for the suspects. The RP reported that there were very few vehicles being driven on the nearby roads and no pedestrians were in sight; this was attributed to the time of day.

About four minutes into the flight, a warning was briefly displayed for about 1-2 seconds on the handheld controller advising the RP to land the UA and check the security of the motor arms. At this point, the UA was 355 m from the TOLA. The RP then proceeded to fly the UA back to the TOLA but shortly after a further series of warnings were displayed, which included a fault with the "propulsion system". The RP then looked up and saw the UA "falling" before it disappeared out of sight. The wreckage of the UA was subsequently found in a residential road. There was no reported damage to property and no injuries to persons.

The operator's procedures required that pre-flight checklists were to be signed off, but the RP had omitted to do this prior to the accident flight and previous flight of the Autel. The RP's Body Worn Video (BWV) system was also to be activated prior to the pre-flight checks. However, the BWV was not turned on until after the UA had taken off.

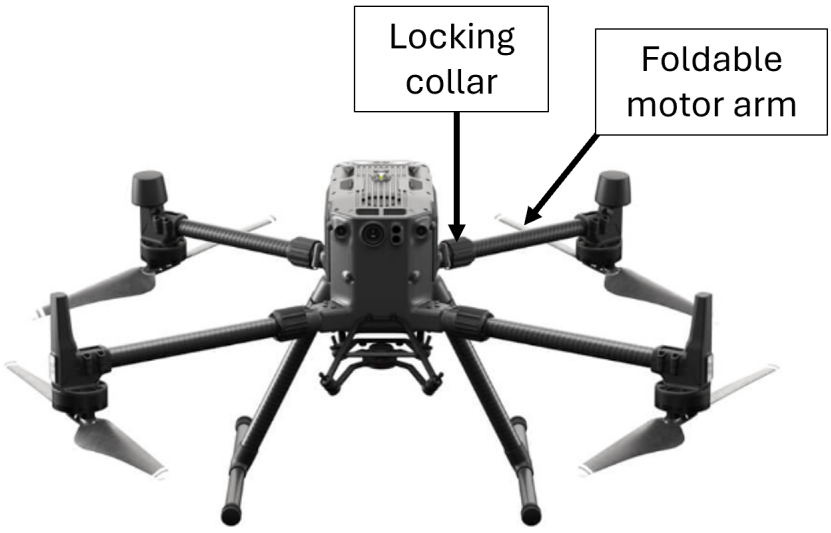


Figure 1

DJI M300
(Imagery courtesy of DJI – not the accident UA)

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Figure 2

TOLA and accident site location
(Imagery ©2025 Google Maps)

Accident site

Wreckage from the UA had spread over a distance of about 20 m from where the main fuselage body had come to rest in a residential road (Figure 3). The UA's batteries had been ejected and were located on an adjacent footpath.



Figure 3

UA wreckage site (courtesy of police)

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Recorded information

The operator downloaded the telemetry flight log from the UAS controller and provided a summary of the data to the AAIB.

At 4 minutes and 4 seconds into the flight, when the UA was at a height of about 380 ft agl (115 m) and 355 m from the RP, the following warning occurred:

- *'Land promptly and check whether frame arm sleeves are tightened securely'*[1].

The RP then started to fly the UA back towards the landing site, but 9 seconds later the following warnings and errors occurred in quick succession:

- *'Aircraft propulsion system error. Force landing. Manually control the aircraft and land in an open area'.*
- *'ESC auto-check error. Return to home and land'.*
- *'Gimbal 1 pitch axis endpoint reached'.*
- *'Aircraft antenna satellite signal searching error. Fly with caution'.*

The UA then started to spin whilst also descending uncontrollably. The telemetry data ended when the UA was at a height of about 250 ft (~75m), at which point its vertical descent rate had reached 3,740 ft/min (37 kt).

Aircraft examination

Inspection of the UA wreckage showed that three of the four motor arm locking collars were still engaged. However, the rear right arm (M4) locking collar was found disengaged from its locking thread (Figure 4); a section of the thread had also detached.

Footnote

[1] The M300 warning to check the motor arms is triggered by detecting excessive vibration. The M300 was superseded by the M350 and M400 UAs, which are equipped with an arm-lock detection system that uses dedicated sensors to monitor the position of the motor arms and prevents the aircraft from taking off if the arms are not locked.

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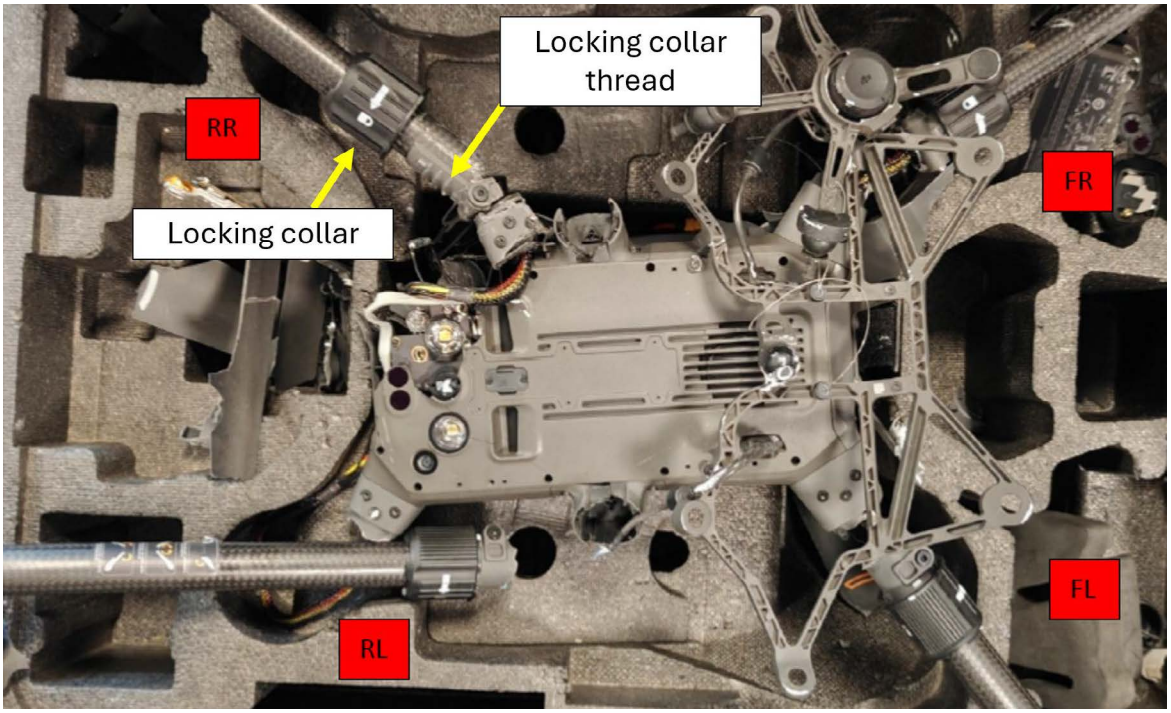


Figure 4

Rear right motor arm locking collar position
(courtesy of police)

Tests and research

The manufacturer of the UA analysed the recorded data and wreckage, from which it concluded '*The accident was caused by the M4* [rear right] *arm not being properly installed'.*

Audits

The operator found that previous audits performed on its UAS operation had not identified that BWVs were not being turned on until after UAs had taken off. The audits had focused on checking that in-flight footage was being captured and had overlooked the need for the pre- flight risk assessments and UA checks to be recorded.

Risk of injury to persons

The M300 takeoff mass was 7.2 kg and its descent rate was 3,740 ft/min at the last recorded data point, which was when the UA was at a height of about 250 ft (~75 m). It is likely that the descent rate would have further increased prior to the UA striking the ground. If it had struck a person on the ground, it is likely that fatal injuries could have occurred.

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Previous M300 accidents

The AAIB has investigated other accidents[2] involving the M300 model of UA where a loss of control has been attributed to motor arms not being fully secured; several of these have occurred whilst operated by the emergency services.

Police UAS operations

The police operate a diverse range of UAS types with more than 800 UA operated nationally by the police. Between 1 June 2025 and 31 May 2026, police forces of England and Wales completed 82,624 flights flown by 1,326 RPs. The national police fleet of M300 consisted of more than 30 UA.

The NPCC is working towards the adoption of common UAS operating procedures where practicable. At this time though, differences exist, which include the content of pre-flight checklists and the use of BWV to capture UAS operations.

Safety action

In response to this accident, the operating police force issued *'Safety Notice (SN) 1/2026-DJI M300 Arm Lock'* dated 24 June 2026. This concluded that *'critical assembly and safety checks were either missed or not verified, directly contributing to the incident'.* The SN introduced a mandatory pre-flight check of the locking collars which included:

- Visual verification that the alignment indicators on the locking collar and UA chassis are correctly aligned (Figure 5).
- An audible and tactile check, that when the locking collar reaches its fully closed position, a mechanical 'click' is heard and 'felt'.
- After each locking collar is locked, to check that there is no movement of the motor arm.

The SN also required that in addition to the RP, the security of the motor arms were to be checked by another RP or flight observer, when available. If the locking collar failed to produce an audible/tactile engagement or the locking thread showed signs of wear, the UA was to be grounded pending rectification. The SN also reminded personnel of the need to follow procedures in activating their BWVs.

In addition to its own UAS team, the SN was uploaded to the 'drones common data platform'. This is a database tool used to collate UAS operational and safety data from across national police forces, with the platform being established in 2024 and managed by the NPCC. It also supports the Drone Air Safety Occurrence Reporting (DASOR)[3] scheme and is used to disseminate safety related information.

Footnote

[2] AAIB investigation to DJI Matrice M300, (UAS registration n/a) 211121 - GOV.UK, AAIB investigation to DJI Matrice 300 RTK, (UAS registration n/a) - GOV.UK, AAIB investigation to DJI Matrice 300, (UAS registration n/a) 170821 - GOV.UK [accessed 14 October 2026].

[3] This is in addition to notifications as required to the AAIB and the UK CAA.

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An NPCC led safety board reviews safety occurrences monthly, with the focus on those classified at 'high' and 'medium' severity levels. These two levels are assigned to accidents or incidents where persons have sustained injury, or injury/and or damage to property was likely or has occurred. The accident involving the M300 was classified as 'medium'. The NPCC took the following safety action:

- Issued a SN (based on 1/2026) to all national police forces operating the M300 UA and informed other UAS state operators, which included the National Fire Chiefs Council (NFCC)[4].
- Recommended that all pre-flight checks for UA that are required to be assembled prior to flight (i.e. those using foldable motor arms) include a visible inspection of any connecting part to ensure the connection is correct and secure.
- Recommended that BWV is activated prior to commencing pre-flight risk assessments and UAS checks as it provides assurance and supports post incident review and organisational learning.

The NPCC also advised that during audits, safety notices and training, it reminds RPs and accountable managers of the need to ensure that operational pressures do not result in safety checks being omitted.

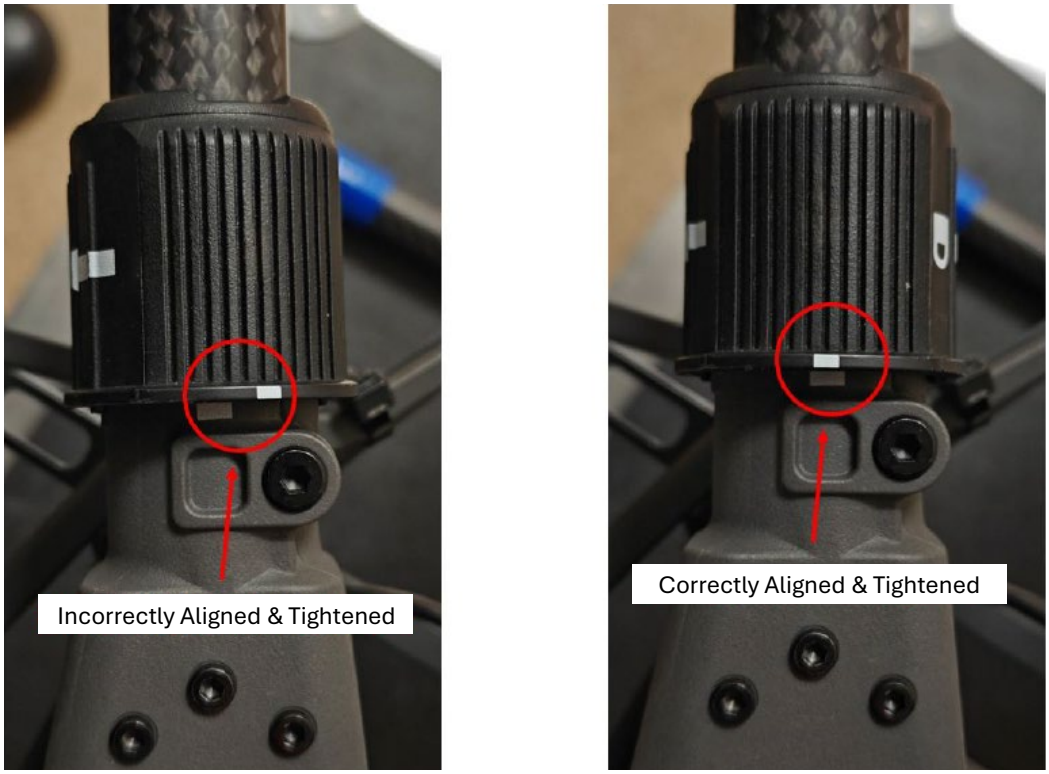


Figure 5

Incorrect and correct alignment of motor arm locking collar (courtesy of police)

Footnote

[4] Via the non-military UAS state Operators Group.

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Conclusion

The data indicated that the rear right motor arm had folded whilst the UA was in flight, which led to an asymmetry of thrust and loss of control. The UAS manufacturer concluded that this had occurred because the motor arm was not properly installed. The normal practice for the operator was for the RPs to place the motor arms into their flight position at the start of their shift duty. However, the operator's procedures thereafter omitted to check that the arms were fully secured prior to each flight. The SN issued by the operating police force is intended to address this, with mandatory checks required.

The lack of adherence to procedures, which included activating BWV prior to flight and not signing off pre-flight checklists are indicative of operational factors. It is possible that the timeliness of getting airborne in a dynamic situation, such as when searching for suspects, could inadvertently result in procedural lapses. The NPCC continues to look to address this, although as the use of UAS and number of flights flown increases, the risk of occasional lapses will likely remain. However, some mitigations may be provided through enhanced technology, such as use of different models of UAS, for which the later M350 and M400 UAS include an arm-lock detection system designed to prevent flight if the motor arms are not fully locked.

This accident again highlights the possible risk of serious injury to persons on the ground when operating UA in residential areas. Had the flight taken place later in the day, when pedestrian and vehicle movements may have been expected to be higher, persons could have been fatally injured. Again, technology may offer some further mitigations though, such as the fitment of parachute systems to UA operating in urban environments.

Safety actions

The operator has taken the following safety action:

> The operator issued Safety Notice 1/2026 that introduced mandatory instructions to ensure that prior to each flight the motor arms on DJI M300 UA are checked to ensure that they are correctly locked and secure.

The NPCC has taken the following safety action:

> Issued a Safety Notice (based on 1/2026) to all national police forces operating the M300 UA and also informed other UAS state operators, which included the NFCC.
>
> Recommended that all pre-flight checks for UA that are required to be assembled prior to flight (i.e. those using foldable motor arms) include a visible inspection of any connecting part to ensure the connection is correct and secure,
>
> Recommended that BWV is activated prior to commencing pre-flight risk assessments and UAS checks as it provides assurance and supports post incident review and organisational learning.

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