Daryl Johnson <u>Pilot</u> <u>MedStar EC-135P1 CDS</u> <u>May 30, 2006</u>

Mr. Johnson was the pilot of the accident helicopter. He was interviewed at the hospital days after the accident, and the following is a summary of the interview.

Mr. Johnson was able to recall portions of the flight. On the day of the accident, he received the flight request, checked the weather, and performed a preflight inspection. He then performed a walk-around inspection with his crew prior to takeoff. The pickup of the patient and the flight to Washington Hospital Center were routine.

According to Mr. Johnson, when the helicopter approached the pad, it "shuffled" and the engine rpm increased. He increased collective pitch, and reduced the throttle on the number 1 engine to control engine and rotor rpm, then aborted the landing. Mr. Johnson was able to control the rpm, and does not recall any visual or aural warnings regarding rpm limits. For the remainder of the flight, the number 1 engine was operated in manual mode, and the number 2 engine remained in automatic mode.

As Mr. Johnson maneuvered the helicopter over the golf course, the "shuffle" worsened, and the helicopter became uncontrollable. He remembered a building and a tree were in the helicopter's flight path as it descended, and maneuvered toward the tree. Mr. Johnson transmitted a "Mayday" call and alerted his crew prior to touchdown.

A follow-up interview was conducted with Mr. Johnson, and he again provided his recollection of the accident flight. His story remained consistent, and he added further details regarding his training and experience in N601FH.

Mr. Johnson recounted a similar event that occurred in March 2006, but he could not recall the exact date. He was flying N601FH, landing at the Washington Hospital Center, when the No. 1 engine increased speed as he initiated the approach. The pilot aborted the landing, performed a go-around, and used manual throttle to control rpm and affect a safe landing. He did not attempt to reset the FADEC.

Once on the ground, Mr. Johnson reported the event to maintenance, but he did not write up the discrepancy, because the maintenance technician responded immediately. The pilot remembered that the FADEC FAIL segment was illuminated, but could not remember what, if any, other lights was illuminated prior to engine shutdown. The technician later reported that the fault "could not be duplicated" and the helicopter was placed back in service. When questioned about his training in the EC-135 helicopter, Mr. Johnson said that all of his training was conducted in Turbomeca engine-equipped helicopters, and that he received no formal training in the EC-135P1 CDS Pratt and Whitney engine-equipped accident helicopter.

The pilot reported that he received classroom instruction on the P1 CDS model, but stated that he had "never" seen an EC-135P1 CDS training manual.

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