RECORD OF CONVERSATION

Investigator Name
Air Safety Investigator
General Aviation Accident Division

Date: 10/02/2018
Person Contacted: Ronel Sizer (medical crew)
NTSB Accident Number: GAA18CA571

Narrative:

Based on the telephone conversation with Ronel Sizer, he stated that prior to departing from Artesia, NM, to pick up a patient with a head injury, the flight crew quickly discussed the weather and conducted an aircraft safety preflight and walkaround. While 15 miles away from Ski Apache, the flight crew attempted to contact the ground crew but to no avail until the helicopter was conducting their high reconnaissance of the landing zone (LZ). The pilot was flying eastbound while requesting an LZ brief for hazards and wind direction when the pilot shouted, “oh, oh!” He then heard the engine change noise and felt the aircraft climbing. Shortly after, the aircraft turned left and subsequently started to sink. He added that there was no communication from the pilot to the medical crew regarding the landing or the sink rate. About 5 feet above the ground, he heard another change in the engine noise, change in the rotor noise, as if it was slowing down, and then the low rotor warning horn. The pilot stated to hold on and the aircraft contacted the ground; the nose came left, tail right. He thought the pilot was going to lower collective and just spread the skids but he saw the pilot raising and jerking on the collective. The aircraft landed hard with the tail first then bounced and slid down the embankment while it rotated about 180º counterclockwise. He felt that the tail struck the ground again and after rotating on the lower level unimproved road, after trying to get the safe call from the pilot, evacuated the helicopter with the other medical crew member.

He also stated that he has over 1.300 patient transports in his career and this is his first accident. He felt crew resource management skills and procedures were lacking, prior to and during the accident flight. He believed that there should be a more formal safety brief prior to takeoff that covered flight plans, aircraft performance, potential hazards and the pre-landing process. He felt that the operation’s aviation safety is self-directed and lacking when it comes to base and company culture assimilation. He added that he received more medical training than flight safety and crew resource management training and believed this happened because he was an experienced medical flight crew.