NTSB MEMORANDUM FOR RECORD

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National Transportation Safety Board

Date: 4/28/2020
Person Contacted: Andrew Rannigan (Pilot in Command)
NTSB Accident Number: ERA20LA160

Narrative:

The following record is a summary of conversation with the individual listed above:

The mission was to move the power line from the top phase to the middle phase. The crane could not get the power line past the arm lip. The helicopter was going to pull the wire laterally about 6 inches to about one foot, to clear the arm and move the wire down.

The long line connected to the powerline, and as the powerline cleared the arm, the pilot experienced a “left yaw” and the engine began “spooling down.” He moved his head inside the cockpit, and then heard the “engine out alarm.” He responded by “slamming the collective down” with his left hand, and as the collective went full down, he then with his left hand pulled the belly band handle upward. After pulling the belly band handle, he moved his hand back to the collective and pulled it upward as the helicopter entered the flare as part of the autorotation. He estimated the power rollback to the time impact with the ground occurred, took about 4-5 seconds.

He reported that when the wire was being moved, the helicopter was not under “high power” and it was only in a “slight nose up” pitch attitude. He said the nose of the helicopter was pointing at the power line structure, and he needed to move the powerline laterally (toward the helicopter), which required an aft movement by the helicopter, that was very small, as the power line did not need to move far. He estimated the loss of power occurred about 150 ft above ground level. He reported he did not have time to pull the main line emergency release handle located on the collective.

He reported that the engine was not running after the helicopter came to rest on its left side on the ground. He evaluated his physical condition and did not believe he was injured and immediately ground personnel assisted his evacuation. Prior to evacuating

he pulled the main fuel shutoff valve and turned the master battery off. He reported there were no anomalies with the engine or any other abnormal indications prior to the loss of power.

He explained that the belly band is a secondary system installed on the helicopter to ensure that if the main long line is disconnected, it will catch on this belly band line. This is critical when humans are on the long lines. He explained that throughout the day, external human operations on the line were being conducted, although, during the loss of engine power, there were no humans on the line. He explained that it was his understanding, removing the belly band constantly throughout the day for human vs non-human line operations could lead to an installation error, and the belly band normally remains installed throughout a day's work, regardless of whether a person is on line.

He reported that as part of his recurrent training, he routinely practiced autorotation's, but had never practiced an autorotation while also having to pull the belly band handle and the main cable emergency release.