Aviation Investigation Final Report

Location:	Round Mountain, Texas	**Accident Number:**	CEN25LA356
Date & Time:	August 31, 2025, 21:02 Local	**Registration:**	N36RP
Aircraft:	SIKORSKY AIRCRAFT CORP S-76	**Aircraft Damage:**	Substantial
Defining Event:	Collision during takeoff/land	**Injuries:**	3 Serious
Flight Conducted Under:	Part 135: Air taxi & commuter - Non-scheduled		

Analysis

The purpose of the on-demand night flight in the helicopter was to transport the passenger from a commercial airport to a private heliport on a ranch in a rural area. Due to previous issues with the helicopter's autopilot system and the possible concern of losing control in instrument meteorological conditions, the captain decided not to perform an instrument flight rules flight to the heliport.

During the flight, an instrument approach was loaded into the helicopter's flight management system, but it was not activated. Additionally, each pilot had an Apple iPad mounted in the cockpit, that was utilizing ForeFlight with the heliport coordinates loaded into ForeFlight. During the approach to the heliport, the captain contacted the ranch manager via text message on a cellular phone, to ensure the heliport floodlight system was activated. The first officer activated the heliport ground lights, which were a green color, via a radio frequency. Both pilots acknowledged observing green lights in their sight. The captain reported that he "cross-checked" the map display with the outside visual references to confirm alignment with the heliport, which he thought had matched. The first officer extended the landing gear, he completed the before landing checklist, and he then transitioned to viewing outside of the helicopter to try and visually acquire the heliport.

The captain delayed turning on the landing lights until closer to the heliport to avoid glare from moisture and haze reflecting in the light beams. The captain began maneuvering the helicopter for landing. Within seconds, the captain lost outside visual references, and he transitioned to instruments. The first officer looked inside the cockpit and observed the radar altimeter indicated 20 ft. Before the first officer could verbally call out to execute a go around, the helicopter terrain awareness and warning system activated an alert, and the helicopter impacted trees and terrain.

The helicopter sustained substantial damage to the fuselage, the main rotor system, the tail boom, the empennage, and the tail rotor system. The captain reported there were no preimpact mechanical malfunctions or failures with the airframe or the two turboshaft engines that would have precluded normal operation.

A review of meteorological data at the time of the accident showed dark night conditions were present for the accident site.

It is likely the flight crew failed to properly identify the heliport in dark night conditions, which resulted in the flight crew attempting to land at the incorrect location. It is also likely the flight crew failed to properly utilize navigation information and visual cues to verify the location of the heliport.

Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be:

The flight crew's failure to properly identify the heliport in dark night conditions, which resulted in the flight crew attempting to land and a subsequent impact with trees and terrain.

Findings

Personnel issues	Incorrect action performance - Flight crew
Personnel issues	Identification/recognition - Flight crew
Personnel issues	Decision making/judgment - Flight crew
Personnel issues	Use of equip/system - Flight crew
Personnel issues	Task monitoring/vigilance - Flight crew
Personnel issues	Situational awareness - Flight crew
Environmental issues	Dark - Effect on operation
Aircraft	(general) - Incorrect use/operation

Factual Information

History of Flight

Landing	Navigation error
Landing	Wrong surface or wrong airport
Landing	Collision during takeoff/land (Defining event)
Post-impact	Evacuation

On August 31, 2025, about 2102 central daylight time, a Sikorsky S-76D helicopter, N36RP, sustained substantial damage when it was involved in an accident near Round Mountain, Texas. The captain, the first officer, and the passenger sustained serious injuries. The helicopter was operated by Paradigm Helicopters, LLC, as a Title 14 *Code of Federal Regulations* Part 135 on-demand flight.

The purpose of the unaided night flight in the transport category helicopter was to transport the passenger from a commercial airport to a private heliport on a ranch in a rural area. Due to previous issues with the helicopter's autopilot system and the possible concern of losing control in instrument meteorological conditions, the captain decided not to perform an instrument flight rules flight to the heliport. Prior to the flight, the captain completed the operator's flight risk assessment tool.

During the flight, an instrument approach was loaded into the helicopter's flight management system, but it was not activated. Additionally, each pilot had an Apple iPad mounted in the cockpit, that was utilizing ForeFlight with the heliport coordinates loaded into ForeFlight.

During the approach to the heliport, the captain contacted the ranch manager via text message on a cellular phone, to ensure the heliport floodlight system was activated. The first officer activated the heliport ground lights, which were a green color, via a radio frequency. Both pilots acknowledged observing green lights in their sight. The captain reported that he "cross-checked" the map display with the outside visual references to confirm alignment with the heliport, which he thought had matched. The first officer extended the landing gear, he completed the before landing checklist, and he then transitioned to viewing outside of the helicopter to try and visually acquire the heliport.

The captain delayed turning on the landing lights until closer to the heliport to avoid glare from moisture and haze reflecting in the light beams. The captain began maneuvering the helicopter for landing. Within seconds, the captain lost outside visual references, and he transitioned to instruments. The first officer looked inside the cockpit and observed the radar altimeter indicated 20 ft. Before the first officer could verbally call out to execute a go around, the

helicopter terrain awareness and warning system activated an alert, and the helicopter impacted trees and terrain.

The helicopter came to rest on its right side. The first officer, who then moved the two engine throttle levers to what he believed was the stop position, was able to egress from the helicopter on his own, while the captain and the passenger were assisted by witnesses and first responders.

The captain reported that he previously landed at the heliport between 20 to 25 times, during both day and night conditions, and that he did not recall experiencing any visual illusions during the accident flight. The first officer reported that he previously landed at the heliport 20 times, but only during day conditions. The accident site, which was a heavily wooded area near a recreational vehicle park on private property, was about 1.54 miles north of the heliport, and a prominent west to east running river separates the two locations.

A review of meteorological data at the time of the accident showed dark night conditions were present for the accident site. While the flight crew reported checking meteorological data from several enroute locations, they did not report checking meteorological data from the closest weather stations near the heliport.

The helicopter sustained substantial damage to the fuselage, the main rotor system, the tail boom, the empennage, and the tail rotor system. The captain reported there were no preimpact mechanical malfunctions or failures with the airframe or the two turboshaft engines that would have precluded normal operation.

The operator reported that the accident could have been prevented by implementing a night vision goggle program for non-airport operations.

Pilot Information

Certificate:	Commercial	**Age:**	64,Male
Airplane Rating(s):	None	**Seat Occupied:**	Right
Other Aircraft Rating(s):	Helicopter	**Restraint Used:**	5-point
Instrument Rating(s):	Helicopter	**Second Pilot Present:**	Yes
Instructor Rating(s):	None	**Toxicology Performed:**	
Medical Certification:	Class 2 With waivers/limitations	**Last FAA Medical Exam:**	February 7, 2025
Occupational Pilot:	Yes	**Last Flight Review or Equivalent:**	April 4, 2025
Flight Time:	(Estimated) 13043 hours (Total, all aircraft), 344 hours (Total, this make and model), 12125 hours (Pilot In Command, all aircraft), 14 hours (Last 90 days, all aircraft), 3 hours (Last 30 days, all aircraft), 1 hours (Last 24 hours, all aircraft)		

Co-pilot Information

Certificate:	Airline transport; Commercial; Flight instructor; Private	**Age:**	55,Male
Airplane Rating(s):	Single-engine land; Multi-engine land	**Seat Occupied:**	Left
Other Aircraft Rating(s):	Helicopter	**Restraint Used:**	5-point
Instrument Rating(s):	Airplane; Helicopter	**Second Pilot Present:**	Yes
Instructor Rating(s):	Airplane multi-engine	**Toxicology Performed:**	
Medical Certification:	Class 1 With waivers/limitations	**Last FAA Medical Exam:**	August 29, 2025
Occupational Pilot:	Yes	**Last Flight Review or Equivalent:**	May 9, 2025
Flight Time:	(Estimated) 6160 hours (Total, all aircraft), 56 hours (Total, this make and model), 3165 hours (Pilot In Command, all aircraft), 151 hours (Last 90 days, all aircraft), 21 hours (Last 30 days, all aircraft), 1 hours (Last 24 hours, all aircraft)		

Aircraft and Owner/Operator Information

Aircraft Make:	SIKORSKY AIRCRAFT CORP	**Registration:**	N36RP
Model/Series:	S-76 D	**Aircraft Category:**	Helicopter
Year of Manufacture:	2013	**Amateur Built:**	
Airworthiness Certificate:	Transport	**Serial Number:**	761037
Landing Gear Type:	Retractable - Tricycle	**Seats:**	10
Date/Type of Last Inspection:	August 4, 2025 100 hour	**Certified Max Gross Wt.:**	11875 lbs
Time Since Last Inspection:	3.6 Hrs	**Engines:**	2 Turbo shaft
Airframe Total Time:	1005.2 Hrs at time of accident	**Engine Manufacturer:**	Pratt & Whitney Canada
ELT:	C126 installed, not activated	**Engine Model/Series:**	PW210S
Registered Owner:	Mirasol Sky LLC	**Rated Power:**	1077 Horsepower
Operator:	Paradigm Helicopters LLC	**Operating Certificate(s) Held:**	On-demand air taxi (135)
Operator Does Business As:	Paradigm Helicopters LLC	**Operator Designator Code:**	86PA

Meteorological Information and Flight Plan

Conditions at Accident Site:	Visual (VMC)	**Condition of Light:**	Night/dark
Observation Facility, Elevation:	KRYW,1231 ft msl	**Distance from Accident Site:**	14 Nautical Miles
Observation Time:	21:15 Local	**Direction from Accident Site:**	46°
Lowest Cloud Condition:	Scattered / 500 ft AGL	**Visibility**	7 miles
Lowest Ceiling:		**Visibility (RVR):**	
Wind Speed/Gusts:	3 knots / None	**Turbulence Type Forecast/Actual:**	None / None
Wind Direction:	60°	**Turbulence Severity Forecast/Actual:**	N/A / N/A
Altimeter Setting:	30.08 inches Hg	**Temperature/Dew Point:**	23°C / 23°C
Precipitation and Obscuration:	Light - None - Rain		
Departure Point:	Dallas, TX (DAL)	**Type of Flight Plan Filed:**	Company VFR
Destination:	Dripping Springs, TX (TA22)	**Type of Clearance:**	None
Departure Time:	19:49 Local	**Type of Airspace:**	Class G

Airport Information

Airport:	MIRASOL HILLS TA22	**Runway Surface Type:**	Grass/turf
Airport Elevation:	1043 ft msl	**Runway Surface Condition:**	Vegetation;Wet
Runway Used:	Helipad H1	**IFR Approach:**	None
Runway Length/Width:	10 ft / 10 ft	**VFR Approach/Landing:**	Full stop;Straight-in

Wreckage and Impact Information

Crew Injuries:	2 Serious	**Aircraft Damage:**	Substantial
Passenger Injuries:	1 Serious	**Aircraft Fire:**	None
Ground Injuries:	N/A	**Aircraft Explosion:**	None
Total Injuries:	3 Serious	**Latitude, Longitude:**	30.343587,-98.157517(est)

Preventing Similar Accidents

Landing at the Wrong Airport (SA-033)

The Problem

Without adequate preparation, robust monitoring, and cross-checking of position using all available resources, flight crews may misidentify a nearby airport that they see during the approach to their destination airport. The risk of an accident increases because the runway at the wrong airport may not be long enough to accommodate the landing airplane, and other aircraft operating at the airport may also be unaware of potential conflicting traffic. Air traffic controllers may not detect a wrong airport landing in time to intervene because of other workload or radar coverage limitations.

What can you do?

- Adhere to standard operating procedures (SOPs), verify the airplane's position relative to the destination airport, and use available cockpit instrumentation to verify that you are landing at the correct airport.
- Maintain extra vigilance when identifying the destination airport at night and when landing at an airport with others in close proximity.
- Be familiar with and include in your approach briefing the destination airport's layout and relationship to other ground features; available lighting such as visual glideslope indicators, approach light systems, and runway lighting; and instrument approaches.
- Use the most precise navigational aids available in conjunction with a visual approach when verifying the destination airport.
- Confirm that you have correctly identified the destination airport before reporting the airport or runway is in sight.

See https://www.ntsb.gov/Advocacy/safety-alerts/Documents/SA-033.pdf for additional resources.

The NTSB presents this information to prevent recurrence of similar accidents. Note that this should not be considered guidance from the regulator, nor does this supersede existing FAA Regulations (FARs).

Administrative Information

Investigator In Charge (IIC):	Hodges, Michael
Additional Participating Persons:	Daniel Latimer; FAA San Antonio FSDO; San Antonio, TX Daryl Collins; Transportation Safety Board of Canada; Gatineau, OF Leslie Ederer; Pratt & Whitney Canada; Longueuil, OF
Original Publish Date:	August 25, 2026
Last Revision Date:	
Investigation Class:	Class 3
Note:	The NTSB did not travel to the scene of this accident.
Investigation Docket:	https://data.ntsb.gov/Docket?ProjectID=200918

The National Transportation Safety Board (NTSB) is an independent federal agency charged by Congress with investigating every civil aviation accident in the United States and significant events in other modes of transportation—railroad, transit, highway, marine, pipeline, and commercial space. We determine the probable causes of the accidents and events we investigate, and issue safety recommendations aimed at preventing future occurrences. In addition, we conduct transportation safety research studies and offer information and other assistance to family members and survivors for each accident or event we investigate. We also serve as the appellate authority for enforcement actions involving aviation and mariner certificates issued by the Federal Aviation Administration (FAA) and US Coast Guard, and we adjudicate appeals of civil penalty actions taken by the FAA.

The NTSB does not assign fault or blame for an accident or incident; rather, as specified by NTSB regulation, "accident/incident investigations are fact-finding proceedings with no formal issues and no adverse parties … and are not conducted for the purpose of determining the rights or liabilities of any person" (Title 49 *Code of Federal Regulations* section 831.4). Assignment of fault or legal liability is not relevant to the NTSB's statutory mission to improve transportation safety by investigating accidents and incidents and issuing safety recommendations. In addition, statutory language prohibits the admission into evidence or use of any part of an NTSB report related to an accident in a civil action for damages resulting from a matter mentioned in the report (Title 49 *United States Code* section 1154(b)). A factual report that may be admissible under 49 *United States Code* section 1154(b) is available here.