



# Aviation Investigation Final Report

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<b>Location:</b>	EL CAJON, California	<b>Accident Number:</b>	LAX01LA009
<b>Date &amp; Time:</b>	October 3, 2000, 14:30 Local	<b>Registration:</b>	N189ND
<b>Aircraft:</b>	Aerospatiale AS350BA	<b>Aircraft Damage:</b>	Substantial
<b>Defining Event:</b>		<b>Injuries:</b>	2 None
<b>Flight Conducted Under:</b>	Part 91: General aviation - Positioning		

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## Analysis

While positioning the helicopter from the ground to a storage cart, the pilot lost directional, made a hard landing, and the tail boom struck the ground. Prior to the loss of directional control, the pilot saw something depart the tail section. He attributed the loss of directional control to a tail rotor failure. He initiated an autorotation over the landing cart. He maneuvered away from the cart in order to land on the ground and prevent a partial landing on the cart. The on-scene investigation revealed the aft drive shaft coupling was detached from the tail rotor drive shaft. Three bolts retain the coupling. One bolt was found attached to the coupling, another bolt was found on the ground, and the third bolt, and two of the retaining nuts, were not located. Neither bolt exhibited stripped threads or deformation. The last maintenance performed on the helicopter was by the previous owner. A track and balance of the tail rotor system was performed about 48 flight hours prior to the accident. According to the manufacturer's maintenance instructions, the balancing is accomplished by placement of washers under the nuts that are used to secure the bolts that attach to the aft drive shaft coupling. These are the same nuts that were not located at the accident site. Maintenance instructions also specify that the bolts in this area should be checked for proper torque and safety after an inspection.

## Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be: Improper torquing procedure of the aft tail rotor drive shaft coupling by maintenance personnel after tracking the tail rotor.

## Findings

Occurrence #1: AIRFRAME/COMPONENT/SYSTEM FAILURE/MALFUNCTION

Phase of Operation: LANDING

Findings

1. (C) MAINTENANCE, ANNUAL INSPECTION - IMPROPER - OTHER MAINTENANCE PERSONNEL
2. (F) ROTOR DRIVE SYSTEM, TAIL ROTOR DRIVE SHAFT COUPLING - DISCONNECTED

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Occurrence #2: HARD LANDING

Phase of Operation: EMERGENCY DESCENT/LANDING

Findings

3. AUTOROTATION - INITIATED - PILOT IN COMMAND

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Occurrence #3: IN FLIGHT COLLISION WITH TERRAIN/WATER

Phase of Operation: LANDING

Findings

4. TERRAIN CONDITION - GROUND

## Factual Information

On October 3, 2000, at 1430 hours Pacific daylight time, an Aerospatiale AS350BA, N189ND, made a hard landing after experiencing a loss of directional control at Gillespie Field Airport, El Cajon, California. Vortex Helicopters, LLC, operated the helicopter under the provisions of 14 CFR Part 91. The helicopter sustained substantial damage when the tail boom contacted the ground. The airline transport pilot and one passenger were not injured. Visual meteorological conditions prevailed for the positioning flight, and no flight plan had been filed.

The helicopter had been returned from another operator after 15 hours of training flights in which a series of full autorotations to the ground were conducted. The purpose of the accident flight was to reposition the helicopter from the ground onto a landing cart for storage. While over the landing cart, the pilot experienced difficulty maintaining directional control. He suspected an antitorque failure and initiated an autorotation. The pilot stated at the time the landing cart was partially beneath the helicopter. The pilot maneuvered away from the cart in order to land on the ground and prevent a partial landing on the cart. As he increased power to maneuver away from the cart, there was a further loss of directional control. After clearing the landing cart, the subsequent hard landing resulted in the tail boom contacting the ground.

In an interview with a Federal Aviation Administration (FAA) inspector, the pilot stated that while he was attempting to land on the cart, he saw something fly off the helicopter prior to losing directional control.

During the on-scene investigation conducted by the FAA inspector, the aft tail rotor drive shaft coupling was found remotely located from the main wreckage. The FAA inspector noted that three bolts retain the coupling. One bolt was found attached to the coupling with no nut. He stated that there was no evidence of the nut having stripped the bolt. The second bolt was found on the ground with the threads intact. He was not able to find the third bolt or the other two nuts.

The FAA inspector reviewed the maintenance logbooks and noted the University of North Dakota, Grand Forks, North Dakota, performed the last annual on March 9, 2000. The University of North Dakota performed a track and balance inspection on the tail rotor system about 48 hours prior to the accident. According to maintenance instructions provided by the manufacturer, the balancing is accomplished by placing washers under the nuts used to secure the bolts that attach to the aft drive shaft coupling. These were the same nuts that were not located at the scene of the accident. A caution to the maintenance instructions specifies that the bolts in this area should be checked for proper torque and safety after an inspection.

The FAA San Diego, California, Flight Standards District Office reported the accident to the

Safety Board on October 12, 2000.

### Pilot Information

<b>Certificate:</b>	Airline transport; Commercial	<b>Age:</b>	50, Male
<b>Airplane Rating(s):</b>	Single-engine land; Single-engine sea; Multi-engine land	<b>Seat Occupied:</b>	Right
<b>Other Aircraft Rating(s):</b>	Helicopter	<b>Restraint Used:</b>	
<b>Instrument Rating(s):</b>	Airplane	<b>Second Pilot Present:</b>	No
<b>Instructor Rating(s):</b>	None	<b>Toxicology Performed:</b>	No
<b>Medical Certification:</b>	Class 1 Valid Medical-w/ waivers/lim	<b>Last FAA Medical Exam:</b>	June 2, 2000
<b>Occupational Pilot:</b>	Yes	<b>Last Flight Review or Equivalent:</b>	
<b>Flight Time:</b>	4000 hours (Total, all aircraft), 75 hours (Total, this make and model), 4000 hours (Pilot In Command, all aircraft), 50 hours (Last 90 days, all aircraft), 40 hours (Last 30 days, all aircraft), 1 hours (Last 24 hours, all aircraft)		

### Aircraft and Owner/Operator Information

<b>Aircraft Make:</b>	Aerospatiale	<b>Registration:</b>	N189ND
<b>Model/Series:</b>	AS350BA AS350BA	<b>Aircraft Category:</b>	Helicopter
<b>Year of Manufacture:</b>		<b>Amateur Built:</b>	
<b>Airworthiness Certificate:</b>	Normal	<b>Serial Number:</b>	2152
<b>Landing Gear Type:</b>	Skid	<b>Seats:</b>	6
<b>Date/Type of Last Inspection:</b>	March 2, 2000 Annual	<b>Certified Max Gross Wt.:</b>	4630 lbs
<b>Time Since Last Inspection:</b>	73 Hrs	<b>Engines:</b>	1 Turbo shaft
<b>Airframe Total Time:</b>	5764 Hrs	<b>Engine Manufacturer:</b>	Turbomeca
<b>ELT:</b>	Installed, activated, did not aid in locating accident	<b>Engine Model/Series:</b>	ARRIEL 1B
<b>Registered Owner:</b>	VORTEX HELICOPTERS, LLC	<b>Rated Power:</b>	510 Horsepower
<b>Operator:</b>		<b>Operating Certificate(s) Held:</b>	None
<b>Operator Does Business As:</b>		<b>Operator Designator Code:</b>	

## Meteorological Information and Flight Plan

<b>Conditions at Accident Site:</b>	Visual (VMC)	<b>Condition of Light:</b>	Day
<b>Observation Facility, Elevation:</b>	SEE ,387 ft msl	<b>Distance from Accident Site:</b>	
<b>Observation Time:</b>	14:53 Local	<b>Direction from Accident Site:</b>	
<b>Lowest Cloud Condition:</b>	Scattered / 1500 ft AGL	<b>Visibility</b>	10 miles
<b>Lowest Ceiling:</b>	Overcast / 2200 ft AGL	<b>Visibility (RVR):</b>	
<b>Wind Speed/Gusts:</b>	10 knots /	<b>Turbulence Type Forecast/Actual:</b>	/
<b>Wind Direction:</b>	260°	<b>Turbulence Severity Forecast/Actual:</b>	/
<b>Altimeter Setting:</b>	29 inches Hg	<b>Temperature/Dew Point:</b>	68°C / 61°C
<b>Precipitation and Obscuration:</b>	No Obscuration; No Precipitation		
<b>Departure Point:</b>	(SEE )	<b>Type of Flight Plan Filed:</b>	None
<b>Destination:</b>		<b>Type of Clearance:</b>	None
<b>Departure Time:</b>	14:30 Local	<b>Type of Airspace:</b>	Class D

## Airport Information

<b>Airport:</b>	GILLESPIE FIELD AIRPORT SEE	<b>Runway Surface Type:</b>	Concrete
<b>Airport Elevation:</b>	387 ft msl	<b>Runway Surface Condition:</b>	Dry
<b>Runway Used:</b>	0	<b>IFR Approach:</b>	None
<b>Runway Length/Width:</b>		<b>VFR Approach/Landing:</b>	Full stop

## Wreckage and Impact Information

<b>Crew Injuries:</b>	1 None	<b>Aircraft Damage:</b>	Substantial
<b>Passenger Injuries:</b>	1 None	<b>Aircraft Fire:</b>	None
<b>Ground Injuries:</b>	N/A	<b>Aircraft Explosion:</b>	None
<b>Total Injuries:</b>	2 None	<b>Latitude, Longitude:</b>	32.789264,-116.95919(est)

## Administrative Information

<b>Investigator In Charge (IIC):</b>	Cornejo, Tealeye
<b>Additional Participating Persons:</b>	GREG NOLTING; SAN DIEGO , CA
<b>Original Publish Date:</b>	November 6, 2001
<b>Last Revision Date:</b>	
<b>Investigation Class:</b>	<a href="#">Class</a>
<b>Note:</b>	
<b>Investigation Docket:</b>	<a href="https://data.nts.gov/Docket?ProjectID=51220">https://data.nts.gov/Docket?ProjectID=51220</a>

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](#).