



# Aviation Investigation Final Report

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<b>Location:</b>	Clay, New York	<b>Accident Number:</b>	NYC01LA167
<b>Date &amp; Time:</b>	July 9, 2001, 17:25 Local	<b>Registration:</b>	N7028V
<b>Aircraft:</b>	Hughes 269A	<b>Aircraft Damage:</b>	Substantial
<b>Defining Event:</b>		<b>Injuries:</b>	2 Minor
<b>Flight Conducted Under:</b>	Part 91: General aviation - Personal		

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## Analysis

The helicopter was in cruise flight when the pilot heard a "bang," and lost tailrotor authority. The pilot maneuvered for landing, and then reduced airspeed in anticipation of landing. The helicopter began to rotate. About 30 to 50 feet agl, the pilot pulled collective to cushion the landing. The helicopter impacted the ground and rolled onto its side. The helicopter received an annual inspection 11 months and 23.3 flight hours prior to the accident. During the annual inspection, the mechanic documented that airworthiness directive (AD) 76-18-01 had been complied with. Examination of the left aft cluster fitting revealed that the tailboom attaching point had separated severing the tailrotor drive shaft. The fracture surfaces for the cluster fitting were relatively flat with smooth curving boundaries, "features typical of fatigue." Most of the relatively rough area in the lower lug had curving arrest lines, "features typical of low-cycle fatigue." AD 76-18-01 stated that within 50 flight hours of the effective date of the AD, and thereafter at intervals not to exceed 50 hours of flight time, or until modifications are accomplished, the tailboom support strut aluminum end fittings were to be visually inspected for deformation or damage, and then checked for cracking using dye penetrant. If cracking or damage was identified the effected structure would have had to be replaced. The AD required the dye penetrant inspection be done in accordance with Service Information Notice N-82.3. In addition, the Service Information Notice stated that a daily visual inspection was required, which the pilot stated he performed prior to the flight.

## Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be: Failure of the left aft cluster fitting due to a fatigue crack. Factors in the accident were the mechanic's failure to identify the crack at the last annual inspection, and the pilot's failure to identify the crack during the last daily inspection

## Findings

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

Phase of Operation: CRUISE

### Findings

1. (C) MISC ROTORCRAFT, TAIL BOOM - FATIGUE
2. (F) MAINTENANCE, ANNUAL INSPECTION - INADEQUATE - OTHER MAINTENANCE PERSONNEL
3. (F) AIRCRAFT PREFLIGHT - INADEQUATE - PILOT IN COMMAND

## Factual Information

On July 9, 2001, about 1725 eastern daylight time, a Hughes 269A, N7028V, was substantially damaged when it rolled over during a precautionary landing near Clay, New York. The certificated commercial pilot and passenger received minor injuries. Visual meteorological conditions prevailed for the personal flight that originated from the Oswego County Airport (FZY), Fulton, New York, destined for the Hancock International Airport (SYR), Syracuse, New York. A flight plan was not filed, and the flight was conducted under 14 CFR Part 91.

According to the pilot, he was in cruise flight when he heard a "bang." He then advised Syracuse Air Traffic Control Tower that he was making a precautionary landing. The pilot identified an area, and turned the helicopter 180 degrees to maneuver for his anticipated landing point. During the turn, the pilot looked back at the tailrotor and saw that it was still rotating, but he did not have tailrotor authority. The pilot lowered the collective and started a descent. He then started to reduce the airspeed in anticipation of landing. The helicopter began to rotate, and 30 to 50 feet agl, the pilot pulled collective to cushion the "fall." The helicopter impacted the ground and rolled onto its left side. The pilot and passenger then egressed.

According to a Federal Aviation Administration inspector, initial examination of the left tailboom support cluster fitting revealed that the left tailboom attaching point had separated, and the fracture surfaces were dark in color. The tailrotor drive shaft was severed where it entered the aft portion of the fuselage. Both sections of the shaft displayed rotational scoring.

According to maintenance records, the helicopter received an annual inspection on July 26, 2000, 23.3 flight hours prior to the accident. During the annual inspection, the mechanic documented that he preformed the requirements of airworthiness directive (AD) 76-18-01

According to a factual report generated by the Safety Board's Materials Laboratory, portions of the fracture surfaces for the cluster fitting lugs were relatively flat with smooth curving boundaries, "features typical of fatigue." Most of the relatively rough area in the lower lug had curving arrest lines, "features typical of low-cycle fatigue."

According to AD 76-18-01, within 50 flight hours of the effective date of the AD, and thereafter at intervals not to exceed 50 hours of flight time, or until modifications were accomplished, the cluster fittings were to be visually inspected for deformation or damage, and then checked for cracking using dye penetrant. If cracking or damage was identified, the effected structure would have had to be replaced. The AD also required the dye penetrant inspection be done in accordance with Service Information Notice N-82.3, which stated that the paint be removed from the fitting prior to the inspection. If the fitting was serviceable, a wash coat of zinc chromate primer, and then a coat of epoxy enamel would have had to been applied. In

addition, the Service Information Notice stated that a daily visual inspection was required.

According to the mechanic, he inspected the cluster fitting in accordance with the AD and the Information Service Notice when he preformed the annual inspection. In addition, the pilot stated that he performed a visual inspection of the aft clevis lugs prior to the first flight of the day, to include the accident flight.

### Pilot Information

<b>Certificate:</b>	Commercial	<b>Age:</b>	46, Male
<b>Airplane Rating(s):</b>	Single-engine land	<b>Seat Occupied:</b>	Left
<b>Other Aircraft Rating(s):</b>	Helicopter	<b>Restraint Used:</b>	
<b>Instrument Rating(s):</b>	None	<b>Second Pilot Present:</b>	No
<b>Instructor Rating(s):</b>	None	<b>Toxicology Performed:</b>	No
<b>Medical Certification:</b>	Class 2 Valid Medical--no waivers/lim.	<b>Last FAA Medical Exam:</b>	September 8, 1999
<b>Occupational Pilot:</b>		<b>Last Flight Review or Equivalent:</b>	May 15, 2000
<b>Flight Time:</b>	14000 hours (Total, all aircraft), 1700 hours (Total, this make and model), 13800 hours (Pilot In Command, all aircraft), 250 hours (Last 90 days, all aircraft), 100 hours (Last 30 days, all aircraft), 6 hours (Last 24 hours, all aircraft)		

### Aircraft and Owner/Operator Information

<b>Aircraft Make:</b>	Hughes	<b>Registration:</b>	N7028V
<b>Model/Series:</b>	269A	<b>Aircraft Category:</b>	Helicopter
<b>Year of Manufacture:</b>		<b>Amateur Built:</b>	
<b>Airworthiness Certificate:</b>	Normal	<b>Serial Number:</b>	76-0622
<b>Landing Gear Type:</b>	Skid	<b>Seats:</b>	2
<b>Date/Type of Last Inspection:</b>	July 26, 2000 Annual	<b>Certified Max Gross Wt.:</b>	1365 lbs
<b>Time Since Last Inspection:</b>	23.3 Hrs	<b>Engines:</b>	1 Reciprocating
<b>Airframe Total Time:</b>	5631.75 Hrs at time of accident	<b>Engine Manufacturer:</b>	Lycoming
<b>ELT:</b>		<b>Engine Model/Series:</b>	HT-36A
<b>Registered Owner:</b>	Mark R. Parker	<b>Rated Power:</b>	180 Horsepower
<b>Operator:</b>		<b>Operating Certificate(s) Held:</b>	None

## Meteorological Information and Flight Plan

<b>Conditions at Accident Site:</b>	Visual (VMC)	<b>Condition of Light:</b>	Day
<b>Observation Facility, Elevation:</b>	SYR,421 ft msl	<b>Distance from Accident Site:</b>	6 Nautical Miles
<b>Observation Time:</b>	17:54 Local	<b>Direction from Accident Site:</b>	145°
<b>Lowest Cloud Condition:</b>	Few / 6500 ft AGL	<b>Visibility</b>	10 miles
<b>Lowest Ceiling:</b>	None	<b>Visibility (RVR):</b>	
<b>Wind Speed/Gusts:</b>	10 knots /	<b>Turbulence Type Forecast/Actual:</b>	/
<b>Wind Direction:</b>	310°	<b>Turbulence Severity Forecast/Actual:</b>	/
<b>Altimeter Setting:</b>	29.76 inches Hg	<b>Temperature/Dew Point:</b>	29°C / 14°C
<b>Precipitation and Obscuration:</b>	No Obscuration; No Precipitation		
<b>Departure Point:</b>	FULTON, NY (FZY)	<b>Type of Flight Plan Filed:</b>	None
<b>Destination:</b>	SYRACUSE, NY (SYR)	<b>Type of Clearance:</b>	None
<b>Departure Time:</b>	16:15 Local	<b>Type of Airspace:</b>	Class G

## Wreckage and Impact Information

<b>Crew Injuries:</b>	1 Minor	<b>Aircraft Damage:</b>	Substantial
<b>Passenger Injuries:</b>	1 Minor	<b>Aircraft Fire:</b>	None
<b>Ground Injuries:</b>	N/A	<b>Aircraft Explosion:</b>	None
<b>Total Injuries:</b>	2 Minor	<b>Latitude, Longitude:</b>	43.180606,-76.170242(est)

## Administrative Information

<b>Investigator In Charge (IIC):</b>	Muzio, David
<b>Additional Participating Persons:</b>	Tom Williams; FAA/FSDO; Rochester, NY
<b>Original Publish Date:</b>	January 2, 2002
<b>Last Revision Date:</b>	
<b>Investigation Class:</b>	<a href="#">Class</a>
<b>Note:</b>	The NTSB traveled to the scene of this accident.
<b>Investigation Docket:</b>	<a href="https://data.ntsb.gov/Docket?ProjectID=52657">https://data.ntsb.gov/Docket?ProjectID=52657</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](#).