



# Aviation Investigation Final Report

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<b>Location:</b>	Loris, South Carolina	<b>Accident Number:</b>	ERA09LA378
<b>Date &amp; Time:</b>	July 2, 2009, 21:00 Local	<b>Registration:</b>	N53963
<b>Aircraft:</b>	Eurocopter AS 350 B2	<b>Aircraft Damage:</b>	Substantial
<b>Defining Event:</b>	Collision during takeoff/land	<b>Injuries:</b>	3 None
<b>Flight Conducted Under:</b>	Part 91: General aviation - Positioning		

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## Analysis

The pilot was performing a visual nighttime approach to a hospital heliport to pick up a patient for transport. The pilot flew the final approach west, into the wind. As the helicopter approached the helipad the two onboard clinicians were calling out obstructions, such as trees and light poles. About 5 feet above the helipad the tailrotor struck a short steel pole adjacent to the helipad. The helicopter shuttered and vibrated, but the pilot was able to continue the landing. Although all three crewmembers had been to the heliport before, they forgot about the short steel poles aligned adjacent to the helipad. The recorded weather at an airport approximately 15 miles northeast of the accident site, about the time of the accident, included calm wind, clear skies, and visibility of 10 miles. After the accident, the hospital removed the short steel poles adjacent to the helipad and the Federal Aviation Administration initiated research into the crew training, operations specifications, and the history of the poles being erected near the helipad. Additionally, the operator's regional safety manager stated that all pilots have begun additional training to position aircraft in such a manner to ensure that all components of the aircraft are clear of all hazards on the periphery or boundaries of marked landing zones/heliports, rather than attempting to place the center of the aircraft at the center of the landing zone/heliport. The operator also initiated a reassessment of hazards at landing zones/heliports within each of their regions' normal operating area, and reported that the information from the reassessments will be added as part of normal preflight briefings and risk assessments.

## Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be: The crew's failure to see and avoid a steel pole during a nighttime approach to the helipad.

## Findings

<b>Personnel issues</b>	Monitoring environment - Flight crew
<b>Environmental issues</b>	Pole - Awareness of condition

## Factual Information

### History of Flight

#### Approach

Collision during takeoff/land (Defining event)

On July 2, 2009, about 2100 eastern daylight time, a Eurocopter AS 350 B2 helicopter, N53963, operated by Omniflight Helicopters Inc., was substantially damaged while landing at Loris Community Hospital Heliport (5SC5), Loris, South Carolina. The certificated commercial pilot and two clinicians were not injured. Night visual meteorological conditions prevailed and a company flight plan was filed for the medical positioning flight conducted under the provisions of 14 Code of Federal Regulations Part 91. The flight originated from Conway-Horry County Airport (HYW), Conway, South Carolina, at 2040.

According to the pilot, the purpose of the flight was to pick up a patient at 5SC5 for transport. The pilot initiated an approach to 5SC5, to the west, into the wind. As the helicopter approached the helipad, the clinicians were "call(ing)" clear of obstructions, such as trees and light poles. About 5 feet above the helipad, the helicopter shuttered and vibrated. The pilot continued the landing and performed an emergency engine shutdown.

A Federal Aviation Administration (FAA) inspector subsequently interviewed the pilot and clinicians. The FAA inspector stated that although all three persons had been to the heliport before, they simply forgot about several steel poles aligned adjacent to the helipad. Just prior to landing, the tailrotor struck one of the steel poles, and the helicopter came to rest on the helipad.

Two of the four steel poles were about 2 feet high and 4 inches in diameter, and the other two were about 3 feet high and 6 inches in diameter. The poles were placed along one side of the helipad along the perimeter line that separated the helipad from a road.

According to the operator's Vice President of Clinical Services, all clinicians are trained with the pilots in Air Medical Resource Management (AMRAM). Through that training, the clinicians are taught to point out obstacles and hazards to flight.

Examination of the helicopter by the FAA inspector revealed damage to the tailboom, tailrotor, tailrotor gearbox, tailrotor drive shaft, main rotor, and horizontal stabilizer.

The recorded weather at an airport approximately 15 miles northeast of the accident site, at 2058, included calm wind, clear skies, and visibility 10 miles.

The pilot had accumulated 2,587 total flight hours in rotorcraft, including 501 hours as pilot-in-command in the Eurocopter AS 350 B2 helicopters. The pilot logged 46, 19, and 2 flight hours

in the previous 90, 30, and 1 days respectively.

Subsequent to the accident, the hospital removed the short steel poles adjacent to the helipad.

The FAA inspector stated that the FAA will research the crew training, ops specs, and the history of the poles being erected near the helipad.

The Eastern Region Safety Manager for Omniflight stated the following in the "Recommendation" section of the NTSB Pilot/Operator Report form:

"The conclusion of the Pilot involved and the Company Chief Pilot was that the incident could have been averted if the landing to the landing zone had been made further into the landing zone as to prevent the tail rotor from impacting any obstruction in the vicinity of the edge of the landing zone. Initial and immediate action has been to indoctrinate all pilots flying into medium to small sized landing zones / heliports to position aircraft in such a manner to ensure that all components of the aircraft are clear of all hazards on the periphery and or confines/boundaries of marked landing zones/heliports rather than attempting to place the center of the aircraft at the center of the landing zone / heliport. Corporate wide reassessment of hazards at landing zones/heliports within each regions normal operating area is underway and will be added/updated as needed and posted as part of normal preflight briefings / risk assessments."

[ This Report was modified on December 21, 2009 ]

### Pilot Information

<b>Certificate:</b>	Commercial; Private	<b>Age:</b>	43, Male
<b>Airplane Rating(s):</b>	Single-engine land	<b>Seat Occupied:</b>	Right
<b>Other Aircraft Rating(s):</b>	Helicopter	<b>Restraint Used:</b>	
<b>Instrument Rating(s):</b>	Helicopter	<b>Second Pilot Present:</b>	No
<b>Instructor Rating(s):</b>	None	<b>Toxicology Performed:</b>	No
<b>Medical Certification:</b>	Class 2 With waivers/limitations	<b>Last FAA Medical Exam:</b>	November 11, 2008
<b>Occupational Pilot:</b>	Yes	<b>Last Flight Review or Equivalent:</b>	December 15, 2008
<b>Flight Time:</b>	2701 hours (Total, all aircraft), 501 hours (Total, this make and model), 1901 hours (Pilot In Command, all aircraft), 46 hours (Last 90 days, all aircraft), 19 hours (Last 30 days, all aircraft), 2 hours (Last 24 hours, all aircraft)		

## Aircraft and Owner/Operator Information

<b>Aircraft Make:</b>	Eurocopter	<b>Registration:</b>	N53963
<b>Model/Series:</b>	AS 350 B2	<b>Aircraft Category:</b>	Helicopter
<b>Year of Manufacture:</b>		<b>Amateur Built:</b>	
<b>Airworthiness Certificate:</b>	Normal	<b>Serial Number:</b>	3963
<b>Landing Gear Type:</b>	Skid	<b>Seats:</b>	4
<b>Date/Type of Last Inspection:</b>	June 29, 2009 AAIP	<b>Certified Max Gross Wt.:</b>	2120 lbs
<b>Time Since Last Inspection:</b>	7 Hrs	<b>Engines:</b>	1 Turbo shaft
<b>Airframe Total Time:</b>	2377 Hrs at time of accident	<b>Engine Manufacturer:</b>	TURBOMECA
<b>ELT:</b>	Installed, not activated	<b>Engine Model/Series:</b>	ARRIEL 1D1
<b>Registered Owner:</b>	US BANCORP EQUIPMENT FINANCE INC	<b>Rated Power:</b>	625 Horsepower
<b>Operator:</b>	OMNIFLIGHT HELICOPTER INC.	<b>Operating Certificate(s) Held:</b>	On-demand air taxi (135)
<b>Operator Does Business As:</b>		<b>Operator Designator Code:</b>	02MA

## Meteorological Information and Flight Plan

<b>Conditions at Accident Site:</b>	Visual (VMC)	<b>Condition of Light:</b>	Night
<b>Observation Facility, Elevation:</b>	CPC,98 ft msl	<b>Distance from Accident Site:</b>	15 Nautical Miles
<b>Observation Time:</b>	20:58 Local	<b>Direction from Accident Site:</b>	45°
<b>Lowest Cloud Condition:</b>	Clear	<b>Visibility</b>	10 miles
<b>Lowest Ceiling:</b>	None	<b>Visibility (RVR):</b>	
<b>Wind Speed/Gusts:</b>	/	<b>Turbulence Type Forecast/Actual:</b>	/
<b>Wind Direction:</b>		<b>Turbulence Severity Forecast/Actual:</b>	/
<b>Altimeter Setting:</b>	29.87 inches Hg	<b>Temperature/Dew Point:</b>	26°C / 18°C
<b>Precipitation and Obscuration:</b>	No Obscuration; No Precipitation		
<b>Departure Point:</b>	Conway, SC (HYW )	<b>Type of Flight Plan Filed:</b>	Company VFR
<b>Destination:</b>	Loris, SC (5SC5)	<b>Type of Clearance:</b>	None
<b>Departure Time:</b>	20:40 Local	<b>Type of Airspace:</b>	

## Airport Information

<b>Airport:</b>	Loris Community Hospital Helip 5SC5	<b>Runway Surface Type:</b>	
<b>Airport Elevation:</b>	91 ft msl	<b>Runway Surface Condition:</b>	
<b>Runway Used:</b>		<b>IFR Approach:</b>	None
<b>Runway Length/Width:</b>		<b>VFR Approach/Landing:</b>	Straight-in

## Wreckage and Impact Information

<b>Crew Injuries:</b>	3 None	<b>Aircraft Damage:</b>	Substantial
<b>Passenger Injuries:</b>		<b>Aircraft Fire:</b>	None
<b>Ground Injuries:</b>	N/A	<b>Aircraft Explosion:</b>	None
<b>Total Injuries:</b>	3 None	<b>Latitude, Longitude:</b>	34.058887,-78.89833(est)

## Administrative Information

<b>Investigator In Charge (IIC):</b>	Gretz, Robert
<b>Additional Participating Persons:</b>	Sean Mosher; FAA/FSDO; West Columbia, SC
<b>Original Publish Date:</b>	March 3, 2010
<b>Last Revision Date:</b>	
<b>Investigation Class:</b>	<a href="#">Class</a>
<b>Note:</b>	
<b>Investigation Docket:</b>	<a href="https://data.ntsb.gov/Docket?ProjectID=74191">https://data.ntsb.gov/Docket?ProjectID=74191</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](#).