National Transportation Safety Board Washington, DC 20594

Brief of Accident

Adopted 06/03/2002

| CHI00FA111 | | | | | | |
|--|--|---------------------------|--|-----------------|-------------------------|----------------------|
| File No. 11719 | 04/14/2000 | St. Paul, MN | Aircraft Reg No. N225LL | | Time (Local): 16:12 CDT | |
| Make/Mode Engine Make/Mode Aircraft Damage Number of Engines Operating Certificate(s) Type of Flight Operation Reg. Flight Conducted Under | Bell / 222U Lycoming / LTS101-750 Substantial 2 On-demand Air Taxi Positioning; Air Medical Part 91: General Aviatio | C-1 (Unspecified) n | Crew Pass | Fatal 0 0 | Serious 0 0 | Minor/None 1 1 |
| Last Depart. Point: Same as Accident/Incident Location Destination: Local Flight Airport Proximity: Off Airport/Airstrip | | | Condition of Light: Day Weather Info Src: Weather Observation Facility Basic Weather: Visual Conditions Lowest Ceiling: None Visibility: 10.00 SM Wind Dir/Speed: 350 / 012 Kts Temperature (°C): 16 Precip/Obscuration: No Obscuration; No Precipitation | | | |
| Pilot-in-Command Age: 39 | | | Flight Time (Hours) | | | |
| Certificate(s)/Rating(s) Commercial; Private; Multi-engine Land; Single-engine Land; Helicopter Instrument Ratings Airplane; Helicopter | | | Total All Aircraft: 3406 Last 90 Days: 87 Total Make/Model: 359 Total Instrument Time: UnK/Nr | | | |

During cruise flight the pilot lost control of the helicopter and an uncontrolled forced landing was made onto the top of a two-story industrial warehouse. The pylon mounted actuator support assembly had separated from the transmission case. The support assembly, attachment hardware, and portions of the transmission case were sent to the NTSB Materials Laboratory for analysis. According to the NTSB Materials Laboratory Factual Report, "... all of the studs showed progressive fatigue cracking from multiple origins." The report stated, "All but one stud fracture ... showed progression from diametrically opposed sides, typical of reversed bending fatigue loads." The report stated that all of the stud and dowel holes in the actuator support were, "... elongated on opposite sides from contact with the respective dowel or stud." The report further stated, "In addition to the elongation of the holes, the faying surfaces of the support and the transmission case were severely worn from relative movement. The directions of indicated movements and wear correspond to the axis of elongation of the respective support holes." The lead mechanic for the helicopter reported that one of the dowel pins was found during routine maintenance approximately one year prior to the accident date and the maintenance staff did not determine the identify the source of the dowel pin.

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Occurrence #1: LOSS OF CONTROL - IN FLIGHT Phase of Operation: CRUISE

Findings

- 1. (C) FLIGHT CONTROL SYSTEM FAILURE
- 2. (C) FLIGHT CONTROL SURFACES/ATTACHMENTS FATIGUE
- 3. (C) AIRCRAFT CONTROL NOT POSSIBLE PILOT IN COMMAND
- 4. (C) MAINTENANCE, INSPECTION INADEQUATE COMPANY MAINTENANCE PERSONNEL
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Occurrence #2: IN FLIGHT COLLISION WITH OBJECT Phase of Operation: DESCENT - UNCONTROLLED

Findings Legend: (C) = Cause, (F) = Factor

The National Transportation Safety Board determines the probable cause(s) of this accident as follows.

The loss of clamp-up force between the transmission case and the pylon mounted actuator support assembly which resulted in fatigue failure of the threaded studs and dowel pins, the failure of the flight control system, helicopter control not being possible after the flight control failure, and the inadequate maintenance procedures by the company maintenance personnel.