National Transportation Safety Board NTSB ID: LAX03FA232 Aircraft Registration Number: N15AH							Imber: N15AH
FACTUAL REPORT		Occurrer	nce Date: 07/12	2/2003	Most Critical I	njury: Se	erious
AVIATION		Occurrer	nce Type: Accio	lent	Investigated E	<sub>by:</sub> NTS	B
Location/Time					•		
Nearest City/Place	State	Z	ip Code	Local Time	Time Zone		
Rancho P.Verdes	CA	g					
Airport Proximity: Off Airport/Airstrip	Distar	nce From L	Landing Facility:		·		
Aircraft Information Summary							
Aircraft Manufacturer			Model/Series	S			Type of Aircraft
Sikorsky			S-58ET				Helicopter
Revenue Sightseeing Flight: No			Air M	Medical Transp	oort Flight: No		
Narrative							
Brief narrative statement of facts, conditions and circumstar HISTORY OF FLIGHT	nces pertir	nent to the a	ccident/incident:				
The pilot made a forced landing, and during the descent the helicopter impacted school bungalows and touched down hard. The helicopter came to rest in a basketball court adjacent to the bungalows, both unoccupied. Aris Helicopters, Ltd., San Jose, California, owned and operated the helicopter. The external load operation was performed under the provisions of 14 CFR Part 133. The helicopter was destroyed, and the commercial certificated pilot was seriously injured. Visual meteorological conditions prevailed at the time. The flight originated from the school property about 1015. On June 9, 2003, Aris provided the contractor with its bid for the helicopter external load operation that involved removing and replacing several dozen air conditioner (AC) units located on top of various school buildings. In the bid, the maximum weight of an individual AC unit was							
<pre>indicated at 2,000 pounds. Th weight was 3,500 pounds. On June 26, 2003, Aris pro "Congested Area Lift Plan" maximum AC unit weight was 2 200 feet above ground level. O</pre>	ovided for 2,500	l the the wo	Federal A ork projec , and the o	viation Adm t. In the perational	inistration (F plan, Aris inf altitude durir	FAA) wi formed	ith the requisite the FAA that the
One of the Aris ground crewmembers reported to the National Transportation Safety Board investigator that the first portion of the July 12, 2003, external load operation was performe without incident. However, after a number of AC units were relocated, the pilot made precautionary landing in an open field on school grounds. The landing was performed after th pilot observed the illumination of a tail rotor gearbox chip light.							ion was performed the pilot made a
The pilot landed and shut d the tail rotor drive shaft's in			-		-	oved th	ne chip plug from
Board investigator that the on it, but he did observe "l	e ground crewmember, who reported that he was near the pilot, further indicated to the Safe ard investigator that the pilot stated he looked at the chip plug and did not observe any met it, but he did observe "lots of black carbon." After the pilot completed his examination, t ip plug was reinserted into its orifice.						
Another of the operator's gr during the examination, prov statement regarding the event:							
	F	FACTUA	L REPORT - A	VIATION			Page 1

TRANSP National Transportation Safety Board	NTSB ID: LAX03FA232	
FACTUAL REPORT	Occurrence Date: 07/12/2003	
AVIATION ETYBON	Occurrence Type: Accident	
Narrative (Continued)		

I accompanied the pilot to the tail area of the helicopter where I observed him open an access door. The pilot removed an object that he indicated was, I think, the chip plug. It was connected to the helicopter with a wire. When the plug was removed, between 1 and 2 ounces of fluid dripped out of this area of the helicopter. I saw the pilot wipe off the plug. I went into the helicopter and obtained a piece of masking tape onto which 2 or 3 little chips were placed. The chips looked like metal objects. I do not know if the pilot actually touched the chips; I did. We both thought it might be metal. The chips had a dark color and definitely had some sort of rigidity to them. They were not sludge-like in feel. The pilot stated something like "this can be a problem."

The pilot did not make any entry into the helicopter's maintenance records regarding his observations of the chip light having illuminated. He did not make any entry into the records of having removed, cleaned, or reinserted the chip plug.

Witnesses reported that the pilot then resumed the external load operation. About five additional lifts were performed before the accident occurred.

The pilot reported to the Safety Board investigator that during flight, seconds before the accident, he had detected a high frequency vibration and the helicopter lost tail rotor thrust. His ground crewmembers reported that while the pilot was repositioning one of the larger sized AC units using the 100-foot-long line, the helicopter suddenly began rotating in a clockwise direction and descending.

During the Safety Board's on scene examination of the wreckage, the input portion of the tail rotor's drive shaft into the IGB was found disconnected from the corresponding output shaft. Metal particles were observed on the gearbox's chip plug, which was found dangling from an electrical connection wire in the tail boom housing adjacent to the IGB.

PERSONNEL INFORMATION:

The pilot held the following FAA airman certificates: airline transport pilot, rotorcraft-helicopters. He had commercial privileges for airplane single engine land and sea, and instrument airplane. The pilot also held a certified flight instructor certificate for rotorcraft-helicopters. The pilot held the following type ratings: BH-14ST, BH-206, and SK-58.

The pilot was hired by Aris Helicopters in 1995, and thereafter, was appointed to the position of chief pilot and check airman. In 2001, his employment with the company ceased, and the pilot acquired employment flying for a municipality. In January 2003, the pilot reacquired employment with Aris, on a part-time basis, and he performed flights under FAR Part 91 and 133.

The pilot reported that his total aircraft and rotorcraft flight times were approximately 14,500 and 13,600 hours, respectively. His total flight time in the accident model of helicopter was 1,500 hours, and he had flown the helicopter 50, 20, and 1.5 hours during the preceding 90-day, 30-day, and 24-hour period.

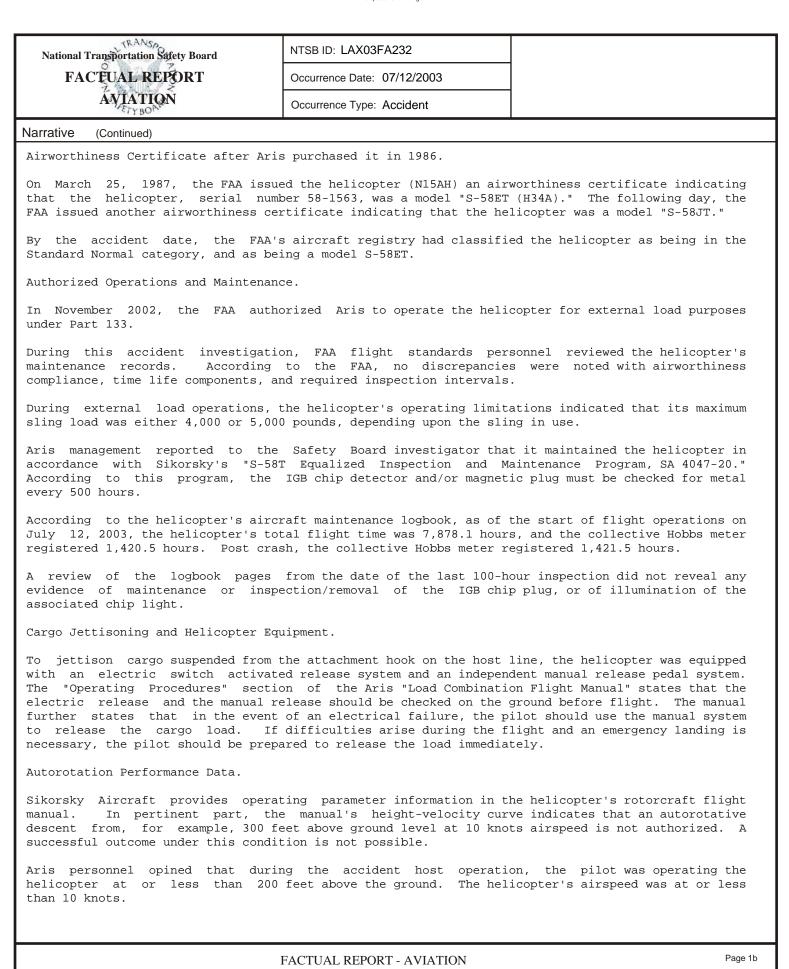
HELICOPTER INFORMATION

Ownership and Model Change History.

The helicopter was manufactured in 1962, and it bore serial number 58-1563. The helicopter was sold to the German Army as a model H-34A. The German Army operated the helicopter until about 1975, when it was converted to an S-58ET and operated by the German Government, Geological Society.

Following an inspection by a team from Sikorsky Aircraft and maintenance, the helicopter was found to conform to FAA type certificate requirements. The FAA issued the helicopter a Standard

FACTUAL REPORT - AVIATION



TRANSP
National Transportation Safety Board
FACTUAL REPORT
AVIATION

NTSB ID: LAX03FA232

Occurrence Date: 07/12/2003

Occurrence Type: Accident

## Narrative (Continued)

#### METEOROLOGICAL INFORMATION:

The closest aviation weather facility to the accident site was at the Torrance Municipal Airport, about 3 miles from the accident site. During the approximate 20-minute period before and after the accident, Torrance reported a variable surface wind between 5 and 8 knots, visibility between 4 and 7 miles, and temperature between 23 and 24 degrees Celsius.

#### COMMUNICATION

None of the operator's employees reported hearing any radio transmission from the accident pilot during the mishap sequence.

## WRECKAGE AND IMPACT INFORMATION

The helicopter was examined at the Miraleste Intermediate School accident site, 3801 Via La Selva, Palos Verdes Estates, California. The site elevation was approximately 900 feet mean sea level. The entire helicopter was found at the site, on an approximate magnetic heading of 070 degrees.

The helicopter was in an upright attitude and on its main wheels. The left main landing gear wheel rim was found fractured; the right side wheel rim was intact. The tail wheel was broken off. Fuel was leaking from the fuel tank. There was no fire.

The fuselage exhibited downward crush signatures, principally in a vertical direction. Transmission supports were observed buckled in a downward direction. No ground scar was evident except directly beneath the wreckage. The vertical distance from the ground to the top of the helicopter's mast was about 8 feet. In an undamaged helicopter, the distance is about 14 feet.

All the main rotor blades were found attached to the swash plate assembly. One of the helicopter's main rotor blades was observed partially resting on top of a school bungalow. The blades exhibited damage signatures consistent with impact marks from structures at the accident site.

The tail rotor blades exhibited either no apparent impact damage, or were crushed in a spanwise direction commencing from the blade tip. No leading edge deformation was apparent. A 1.5-inch-deep ground scar depression in the asphalt-covered ground, a few feet from one of the tail rotor blades, matched the size and orientation of a tail rotor blade's spanwise crushed tip. No deformation signature consistent with blade rotation was observed. All of the tail rotor blades were found attached to the tail rotor drive assembly. All couplings to the tail rotor drive shaft were found intact.

When the input shaft to the IGB was rotated by hand, the output shaft did not rotate. The IGB's case housing was observed cracked. The IGB's chip plug was found outside the gearbox receptacle. The chip plug was found inside the tail boom and was hanging by a connecting wire next to the IGB.

The 100-foot-long cargo host line was found strung out between the impact damaged (dropped) AC unit, which was reportedly being lifted at the time of the mishap, and the main wreckage (see photographs).

The helicopter was equipped with two independent mechanisms to release cargo, an electric switch and a manually operated foot pedal. The cockpit-arming switch for the sling release was found in the SAFE position. Aris personnel opined that the switch should have been set to the Cargo Sling position, which would have permitted the electric switch (button) on the cyclic control to operate. The electrically activated release button on the cyclic control was impact damaged.

The manual sling release pedal mechanism connected to the cargo line hook was functionally tested. It was found operational.

FACTUAL REPORT - AVIATION

TRANSP National Transportation Safety Board	NTSB ID: LAX03FA232	
FACTUAL REPORT	Occurrence Date: 07/12/2003	
AVIATION	Occurrence Type: Accident	
Narrative (Continued)		

TESTS AND RESEARCH

Under the direction of the Safety Board investigator, and with the on-scene supervision of FAA personnel, the helicopter's IGB assembly, segments of the input and output drive shafts with attached flex couplings, and the associated chip detector were examined by the Sikorsky Aircraft Company. Sikorsky's Material Laboratory issued a metallurgical examination report, number MER-6813d-Rev. 1. (On December 1, 2005, Sikorsky's Chief, Aircraft Safety Investigation, advised the Safety Board investigator that its examination report could be released as a public document.) As indicated in the report, the component examination revealed the following:

A lack of drive continuity was found to be due to a large segment of the input [pinion] gear, comprising approximately seven gear teeth, having fractured in the intermediate gearbox. Considerable damage to other components in the assembly was also observed; all of it was considered to have been secondary to the fracture of the input gear.

Regarding the nature of the fractured input gear, Sikorsky reported that "the fracture had a fatigue appearance, with the origin in a gear tooth root, at the drive side fillet radius, approximately 3/16" from the heel end face, in a noncontact area. There were no discontinuities optically visible at the origin, and the teeth flanks and roots had a uniform shot peened appearance. The initial propagation mode was fatigue in nature, transitioning to apparent cyclic overload in the web region, with many crack arrest markings visible along the extent of the fracture surface. A final overload zone where fracture once again intersected the teeth eventually allowed release of the entire segment." Evidence was found indicating that the IGB had previously been overhauled.

The data plate on the IGB bore the following marks: MFRS ASSY DWG. S1635-64100-041 MFRS S/N S1-58-1420 Order No. W.O. 1195

The input (pinion) gear that was found fractured bore the following marks: Stamped (etched) marks: 16\*35-64114-G FZ B/L 007 Hand written (etched marks: FZ21 TS-20\*01 S/N AH-713 [\* Represents best estimate of number/letter]

Intermediate Gearbox Installation and Pinion Gear Component History.

Aris provided historical records listing the helicopter's installed components by part number, serial number, and maintenance history. The subject pinion gear was identified in its records as follows: P/N S1635-64114-101

S/N AH713/F721

In addition, the following remarks were written on the tag: "C/W shotpeening NDT, inspected OK. O/H'd ASB 58B35-26A C/W. Printed on the tag, in part, was the following statement: "The item identified above was inspected...and is approved for return to service...."

FACTUAL REPORT - AVIATION

FACTUAL REPORT     Occurrence Date: 07/12/2003       AVIATION     Occurrence Type: Accident	National Transportation Safety Board	NTSB ID: LAX03FA232	
AVIATION Occurrence Type: Accident	FACTUAL REPORT	Occurrence Date: 07/12/2003	
	ANIATION ETYBON	Occurrence Type: Accident	

# Narrative (Continued)

Sikorsky's Chief, Aircraft Safety Investigation, reported to the Safety Board investigator that after the input pinion is reworked pursuant to all the procedures indicated in Alert Service Bulletin No. 58B35-26, the component is to be marked with the following letters "TS-200-1." Input pinions marked with "TS-200-1" are assigned a life limit of 2,000 hours per the ASB.

According to a "Component Log Card," the input bevel gear, identified by serial number AH713 F721 TS-200-1 was installed in N15AH on June 3, 1994. At the time, the helicopter's time was listed as being 6,054.5 hours.

On a document bearing the name Sikorsky Aircraft, and referring to the major component named "Intermediate Gear Box," S/N 58-1420, the subject input bevel pinion gear was listed with the remarks "Retire in 2000 hours."

Based upon the subject pinion gear having zero time, a 2,000-hour life limit, and having been installed in the helicopter at 6,054.5 hours, the part's life would expire at 8,054.5 hours. The accident helicopter's total time at impact was 7,879.1 hours (7,878.1 hours at the start of the day's flight, plus 1.0 hour during the day's flight). The subject pinion gear broke about 175.4 hours prior to reaching its life limit (8,054.5 - 7,879.1 hours).

# ADDITIONAL INFORMATION

The main helicopter wreckage was released to the owner's assigned insurance adjuster on July 14, 2003. No original records were retained.

National Transportation Safety Board	TSB ID: LAX03FA232										
FACTUAL REPORT	Occi	urrence l	Date:								
AVIATION	Occ	urrence	Type:	Accident							
Landing Facility/Approach Information			. jpo:								
Airport Name	,	Airport	t ID:	Airport Elevation	Run	way Used	Runwa	ay Length	n Rur	way Width	
	ļ	[ .		Ft. MSL		NA				2	
Runway Surface Type:			I			I			I		
Runway Surface Condition:											
Approach/Arrival Flown: NONE											
VFR Approach/Landing: None											
Aircraft Information											
Aircraft Manufacturer			Model/\$ S-58E					Serial N 58-15	Number		
Sikorsky			S-00∟	.1				00-10	03		
Airworthiness Certificate(s): Normal											
Landing Gear Type: Tailwheel											
Amateur Built Acft? No Number of Seats	: 11			Max Gross Wt.		13000		Number	r of Engine		
Engine Type: Turbo Shaft		-		nufacturer: /hitney		Model/Ser PT6T-6	ies:			ed Power: 75 HP	
- Aircraft Inspection Information											
Type of Last Inspection					Time Si	nce Last Inspe			Airframe T		
100 Hour		06/2003				11 Hours				7879 Hours	
- Emergency Locator Transmitter (ELT) Information											
ELT Installed?/Type Yes /		ELT C	ELT Operated? Yes ELT Aided in Locating Acci					ent Site?	No		
Owner/Operator Information											
Registered Aircraft Owner		St	treet A	ddress 1138 Colema	n Avenı	IA	_				
ARIS Helicopters, Ltd.		City							State	Zip Code	
			To ot A	San Jose CA 95110							
Operator of Aircraft		Su	reet At	1138 Colema	n Avenı	Je					
ARIS Helicopters, Ltd.		City San Jose						State CA	Zip Code 95110		
Operator Does Business As:					0	perator Design	ator Co	de: CA	XL	1	
- Type of U.S. Certificate(s) Held:											
Air Carrier Operating Certificate(s):											
Operating Certificate: Operator Certificate: Aircraft External Load											
Regulation Flight Conducted Under: Part 133: Roto	orcraft E	xt. Loa	ad								
Type of Flight Operation Conducted: Other Work Us	se										
	FACT	'UAL R	REPOI	RT - AVIATION						Page 2	

			Т										
National Transportation Safety Board NTSB ID: LAX03FA232													
FACTUAL RI	EPØRT		Occurren	ce Date: 0	7/12/2003	3							
乙酸酸乙酸	<i>X</i> <												
AVIATI ETY BO	APAT		Occurren	ce Type: A	ccident								
First Pilot Information													
Name					City State Date of E						Date of Birth		Age
On File					On File				0	n File	On File		51
Sex: M Seat Occupied	: Right	Oc	cupational Pi	ilot?				(	Certific	ate Num	ber: On File		1
	ne Transpor							I					
Airplane Rating(s): Single-engine Land; Single-engine Sea													
Rotorcraft/Glider/LTA: Helic	copter												
	iane; Helico	oter											
Instructor Rating(s): Non													
Current Biennial Flight Revie	ew? 12/2002	2											
Medical Cert.: Class 2	Medica	al Cert. Statu	s: With Wai	ivers/Limita	ations			Date of	f Last I	Medical E	Exam: 12/200	)2	
- Flight Time Matrix	All A/C	This Make and Model	Airplane Single Engine	Night			Ins	Instrument Actual Simulated		Rotorcraft	Glider		Lighter Than Air
Total Time	14500	1500	900	C	) 17	700	80	800 2		136	00	0	
Pilot In Command(PIC)	14300	1500	900		17	700	80	0	200	134	00		
Instructor	500	50								5	00		
Instruction Received													
Last 90 Days	100	50											
Last 30 Days	40	20											
Last 24 Hours	2	2			_								
Seatbelt Used? Yes	Shou	ulder Harness	s Used? Yes	i	Т	oxico	logy Perfo	rmed? N	0	s	econd Pilot?	No	
Flight Plan/Itinerary													
Type of Flight Plan Filed: No	one												
Departure Point						State	Air	port Ident	tifier	Depa	rture Time	Т	ime Zone
Same as Accident/Incide	ent Location									1015			PDT
Destination						State		Airport Identifier					
Local Flight						Siale		portiden	unei				
Type of Clearance: None													
Type of Airspace:													
Weather Information													
Source of Wx Information:													
Unkno	wn												
			FACTUAI	DEDUDA	Α ΥΤΑ Τ	FION	J						Page 3
1			INCIUAL			101	•						

National Transportation Safety Board				B ID: LAX03								
	ACTUAL REPOI		Occ	Occurrence Date: 07/12/2003								
	AVIATION ETYBON			urrence Type:				1				
Weather					/ 1001001							
Weather Information           WOF ID         Observation Time         Time Zone				Elevation	WOF D	istance From	n Accio	dent Site		Direction Fr	om Accident Si	te
-												
ТОА	0957	PDT	1	03 Ft. MSL				3 NM		336 Deg. Mag.		
Sky/Lowes	st Cloud Condition: Fev	v				Ft. AG	L	Condition of	of Ligh	nt: Day		
Lowest Ce	iling: Broken		1500	00 Ft. AGL	Visib	ility:	4	SM	Alti	meter:	30.05	"Hg
Temperatu	ıre: 23 °C	Dew Point:	18	3 °C Weath	ner Condi	tions at Acci	dent S	<sub>lite:</sub> Visual	Cond	litions		
Wind Direc	tion: Variable	Wind Spe	ed: 5	•	Wine	d Gusts:						
Visibility (F	RVR): Fi	t. Visibility	(RVV)	SM								
Precip and Haze	I/or Obscuration:											
Accident	Information											
Aircraft Da	mage: Destroyed		Aircra	Aircraft Fire: None					olosio	n None		
- Injury Su	mmary Matrix	Fatal	Serious	Minor	None	TOTAL						
First Pi	lot		1			1						
Second	d Pilot											
Studen	t Pilot											
Flight I	nstructor											
Check	Pilot											
Flight E	Engineer											
Cabin /	Attendants											
Other 0	Crew											
Passer	ngers											
	ABOARD -		1			1						
Other (												
- GRANE	D TOTAL -		1			1						
			FACT	UAL REPO	RT - AV	IATION						Page 4

National Transportation Safety Board	NTSB ID: LAX03FA232	
FACIDAL REPORT	Occurrence Date: 07/12/2003	
AVIATION	Occurrence Type: Accident	
Administrative Information		
Investigator-In-Charge (IIC)		
Wayne Pollack		
Additional Persons Participating in This Accident/Incid	lent Investigation:	
Kenneth Brock Federal Aviation Administration Long Beach, CA		
	FACTUAL REPORT - AVIATION	Page 5