

P84 Jet Provost T MK4, G-TOMG

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Aircraft Type and Registration:	P84 Jet Provost T MK4, G-TOMG
No & Type of Engines:	1 Bristol Siddeley Viper MK 20201 turbojet engine
Year of Manufacture:	1963
Date & Time (UTC):	1 August 1999 at 1152 hours
Location:	Woolaston, Gloucestershire
Type of Flight:	Private
Persons on Board:	Crew 1 - Passengers - 1
Injuries:	Crew - 1 Fatal - Passengers - 1 Fatal
Nature of Damage:	Aircraft destroyed
Commander's Licence:	Private Pilots Licence
Commander's Age:	43 years
Commander's Flying Experience:	1,043 hours (of which 57 were on type) Last 90 days - 32 hours Last 28 days - 12 hours
Information Source:	AAIB Field Investigation

History of flight

The aircraft was operating a series of pleasure flights over the course of a weekend from Gloucester Staverton Airport. The weather during the weekend was very warm and the visibility was sometimes hazy. Three different pilots flew the aircraft on these trips, taking passengers who were members of a local flying club. Payment was made by each passenger as a part contribution to the costs of the flight. Briefings were conducted in small groups before the flights with particular reference to the use of the ejection seats and safety procedures. Each flight was planned to be of either 30 minutes or one hour duration.

The pilot for the accident flight had flown three such flights on the Saturday; this was his first flight on Sunday. The aircraft was refuelled to full tanks before departure and the passenger, who held a Private Pilots Licence (PPL), was assisted with strapping in. The aircraft took off from Runway 09 and turned left to depart from the airport circuit area. A recorded radar track showed the aircraft climbing from Staverton and then heading southwest at a speed of about 200 kt. At the point where the aircraft crossed over the Severn Estuary, the radar contact was lost and there were no further contacts. It was estimated that the lowest altitude at which the radar could have detected the aircraft was about 600 feet.

The aircraft was seen from the west bank of the River Severn heading in a south-easterly direction, flying along the middle of the river at a height described as about 50 feet. Several other people described seeing the aircraft flying 'very low' along the river. Before reaching the Severn

Road Bridge the aircraft entered a climbing turn to the right, the turn taking the aircraft over the west bank and rising ground. On completion of the turn the aircraft headed north-east and descended again towards the river. The aircraft passed close by a house and the occupants, who were in the garden, thought the aircraft clipped the top of a nearby tree, but later inspection showed no evidence of damage to the tree. They continued to watch the aircraft and saw it fly up the river for a short time before returning sharply to the left. During the turn to the left, they saw the aircraft descending close to the ground.

A number of witnesses saw the aircraft carrying out its final turn and described seeing it in a steep bank to the left whilst at a low level. During the turn the nose of the aircraft was seen to drop and the aircraft descended towards the ground. There were no witnesses to the actual impact but people close by reported that there was an immediate fire. Some people in the area also heard the sound of the aircraft and its engine before impact.

Pilot experience

The pilot gained his PPL in 1990 and first flew G-TOMG in 1996. He completed a conversion course of some 23 hours dual instruction, and first flew the aircraft solo in February 1998. He was subsequently approved to authorise his own flights in the aircraft. The passenger held a PPL and had recorded a total flight time of about 150 hours. He had no previous experience on this type of aircraft.

Meteorology

The 1150Z weather report from Staverton was as follows:

Surface wind 170°/8 kt, visibility 12 km, haze, few cumulus cloud at 4,000 feet, temperature 29°C and QNH 1014.

Another pilot had reported earlier in the day that to the southwest of the area, out in the Severn Estuary, the visibility was less good and the horizon was indistinct.

Pathology

There was no evidence of any medical factor having an influence on this accident. Both pilots sustained fatal injuries at the time of the impact.

Operation of the aircraft

The aircraft was operated on a Permit to Fly and in accordance with the operational requirements detailed in Civil Aviation Publication (CAP) 632. This required the operator to produce an approved Organisational Control Manual, (OCM) setting out the operational procedures for the aircraft. One of the operators requirements for the carriage of passengers was that the intercom system should be fully serviceable. There was no stated policy regarding low flying, nor was there any such requirement in CAP 632. Rule 5(1)e of The Rules of The Air Regulations 1996 states:

An aircraft shall not fly closer than 500 feet to any person, vessel, vehicle or structure.

Article 119 of The Air Navigation Order (ANO) allows that a flight will be deemed private if payment made is a share of the direct cost of the flight to the pilot.

Aircraft handling

Pilot's notes for the Jet Provost T Mk 4 include the following two items of information:

During turns and pull-outs at speeds below 190 kt mild airframe buffet indicates the approach to a stall.

At low altitudes, if the aircraft is descending, the minimum safe height for ejection is roughly one-tenth of the rate of descent. If the wings are not level this minimum increases rapidly as the angle of bank becomes larger.

The normal cruise airspeed for the aircraft is 220 to 240 kt. The recovery procedure from a steep turn at low level in which the nose of the aircraft had dropped would necessitate a roll to decrease the bank angle, followed by a pull up to regain height.

The recommended method for initiating ejection, if time is short, is to use the seat pan firing handle. The canopy would be jettisoned immediately and the seat would follow within 0.6 seconds. There was no evidence that an ejection had been attempted.

Previous flights

Three people had been for flights with the accident pilot on the previous day. Two of them described flying at low level along the Severn Estuary and also flying low over lakes and reservoirs in the Brecon Beacons area. They both reported that they were given the opportunity to fly the aircraft themselves but not while operating below about 1,000 feet. A number of passengers in the aircraft over the weekend stated that the intercom system was not working well during their flight.

Location of the accident

The aircraft was flying close by the west bank of the River Severn immediately before the accident. In the vicinity of the initiation of the final left turn there was a low lying rocky outcrop known as Guscar Rocks. These rocks tend to attract a number of seabirds and the area was popular with birdwatchers. On the landward side of these rocks, towards which the aircraft turned, there was a railway embankment and then rising ground towards some farm buildings.

Engineering investigation

The accident site

The aircraft had crashed on a slight up-slope, near the almost flat top of a low hill, at a height of about 50 feet amsl and whilst on a track of about 295° M. This was consistent with the aircraft having been turned through approximately 120° to the left from the heading reported by witnesses as that used by the aircraft when it returned up the estuary towards Staverton. The field in which it crashed had a crop of standing wheat.

The aircraft had first struck the ground with its left wingtip, which initiated a rapid yaw to the left. From the evidence of the ground marks resulting from the impact and ground-slide, it was determined that the aircraft attitude at the time of impact was slightly rolled to the left with the fuselage slightly nose down. By the time the nose and right wing contacted the ground, the aircraft had yawed considerably to the left. The initial impact had severed the left wingtip near the inboard end of the aileron cut-out, and the impact of the nose destroyed the forward fuselage.

The aircraft had slid on its underside for about 40 yards before coming to rest, upright and heading about 170° M. During the course of the ground-slide, both ailerons and the left elevator separated from the aircraft and the right wing became tucked underneath the fuselage. The wreckage of the cockpit area was forward and to the right of where the fuselage had come to rest. Both ejection seats were present and had partially broken up, but neither of the firing handles of either seat had been operated; the canopy frame was also present in the cockpit wreckage.

The impact disrupted the aircraft's fuel tanks and the spilled fuel and crop caught fire immediately after the impact. There had been a fierce fuel fire where the aircraft came to rest, which melted the left side of the fuselage, the left tailplane and the rudder. The fire had also melted the skins of the wings, which were lying uppermost under the centre fuselage, melted a hole in the side of the engine compressor case and had spread into the area of the cockpit wreckage. The fire in the wheat crop had spread extensively to the north of the accident site.

The aircraft wreckage was recovered from the field and taken to the AAIB facility at Farnborough for further examination.

Detailed examination

Although the aircraft had been extensively broken up by the impact and further destroyed by the post crash fire, there was sufficient evidence, both from the distribution of the wreckage at the accident site and during examination at the AAIB facility, to indicate that it had been structurally intact before impact. There was also evidence that the aircraft was in a clean configuration, with the landing gear; flaps and airbrakes all retracted.

Examination of the main flying controls showed evidence that all control circuits had been intact up to the time that the aircraft had started to break up but the degree of break-up and fire damage to the structure precluded the possibility of establishing that there had been no control restrictions in flight. However, evidence of contact of the left aileron horn against the end of its cut-out in the wingtip at impact indicated that the ailerons were positioned to roll the aircraft to the right, out of the left bank. It was not possible to determine the impact positions of any other flying control surfaces or of the controls in the cockpit but, as found, both pilots throttle control levers were in a similar position at about 75% of the travel towards the maximum power setting. The airspeed indicator, which had had its glass crushed onto the dial face during the impact sequence, showed an indication of 138 kt; there was no evidence of a needle witness mark at a speed above this.

A strip examination of the engine was performed with the assistance of the manufacturer. This showed that the engine had been turning at the time of impact and some vegetable debris had been drawn through to the turbine section. There was no pre-impact damage due to foreign objects on the blades of any stage of the compressor. The only damage was the result of heat from the external fire causing local melting of the compressor case and the aluminium compressor blades in the affected zone.

The fuel control unit was fragmented and the pump severely burned so that it was not possible to test either component. It was, however, possible to determine the stroke setting of the fuel pump, as found, which was consistent either with the engine having been running at a constant speed between 73 and 90% or to have been accelerating from some speed higher than flight idle.

History of the aircraft

The aircraft first entered service with the RAF in 1963, as XR674, and after service at a number of flying training stations was put into storage in 1989, having flown nearly 7,600 hours. It was subsequently used as a ground trainer and, having been declared surplus to requirements, was bought in 1993 as a non-flying machine by the predecessor of the organisation which subsequently maintained it. They also acquired a replacement engine, which had recently undergone a minor repair by the manufacturer and had 650 hours operating life remaining. The aircraft was then purchased by one of the members of the group who subsequently operated it, and who

commissioned the maintenance organisation to bring the aircraft up to flying condition. The restoration of the aircraft was completed over the space of two years, since when it had flown a total of about 260 flying hours without a significant unserviceability.

The maintenance organisation has CAA A820 approval for the maintenance of ex-military jet aircraft and the staff includes personnel with responsible service experience of maintaining this aircraft type. They impose a condition on operators of jet aircraft which they are maintaining, that aircraft have a current 25-hour/90 day certificate of maintenance release. The operating group of GTOMG had accepted that condition and ensured that they complied with it. The last release certificate had been issued on 27 July 1999 and valid until 25 October 1999 or 25 flight hours.

Discussion

The short groundslide of such a relatively substantial aircraft after a shallow angle impact indicated that the aircraft had a relatively low energy at that time, even allowing for the retarding effect of the crop. The characteristics of the accident site were consistent with the reading of 138 kt which was retained on the airspeed indicator.

There is an inherent degree of risk in flying at very low levels. Any error by the pilot, any failure of the aircraft or any adverse external factor leaves little safety margin. The pilot was flying within the terms of the OCM but had limited experience, and no training in flying at heights below 500 feet.

Neither the information gained from interviewing witnesses nor the investigation of the wreckage revealed any apparent reason why the aircraft should have entered a steep turn to the left at low level. There is a possibility that bird avoidance was involved but there was no evidence of a bird strike. There is evidence that the aircraft was flying at about 140 kt when it hit the ground. The turn may have been initiated at less than the normal cruise airspeed of 220 kt, or during the turn the speed could have reduced and the nose of the aircraft dropped causing the aircraft to descend towards the ground. The low airspeed would have made a recovery more difficult to achieve.

There appeared to have been a late attempt to roll out of the turn. This is consistent with the witness evidence of the aircraft being seen in a steeply banked turn and the evidence of the ground marks indicating that the aircraft was relatively level in roll at the point of impact. The evidence of an out-of-turn roll control input suggests that there was not a restriction in the roll control at the time of impact. The positions of all the ejection seat firing handles and the presence of the canopy frame components amongst the forward fuselage wreckage were consistent with there being no attempt at ejection by either occupant.

The passenger would have expected to fly the aircraft for some part of the flight but it is unlikely that he was doing so at the time of the accident. The pilot on previous flights had only handed over control to passengers when flying at heights in excess of 500 feetagl.

Recommendation2000-13

The following safety recommendations are made:

The CAA should consider amending the guidelines given to operators in CAP 632 to require a minimum operating height to be specified in the Organisational Control Manual when passengers are carried.

Recommendation2000-14

The CAA should consider amending the guidelines given to operators in CAP 632 to require a minimum level of experience specified in the Organisational Control Manual before a pilot is authorised to carry passengers.