

# SA365C1 Dauphin, G-PLMI

## AAIB Bulletin No: 1/98 Ref: EW/C97/7/6 Category: 2.2

<b>Aircraft Type and Registration:</b>	SA365C1 Dauphin, G-PLMI
<b>No &amp; Type of Engines:</b>	2 Turbomeca Arriel 1A-1 turboshaft engines
<b>Year of Manufacture:</b>	1977
<b>Date &amp; Time (UTC):</b>	20 July 1997 at 1900 hours
<b>Location:</b>	En-route between Troon and Turnberry
<b>Type of Flight:</b>	Public Transport
<b>Persons on Board:</b>	Crew - 1 - Passengers - 1
<b>Injuries:</b>	Crew - None - Passengers - None
<b>Nature of Damage:</b>	Detached horizontal stabiliser
<b>Commander's Licence:</b>	Airline Transport Pilot's Licence (H)
<b>Commander's Age:</b>	N/K
<b>Commander's Flying Experience:</b>	6,920 hours (of which 16 hours were on type) Last 90 days - N/K Last 28 days - N/K (but 20 hours flown in last 7 days)
<b>Information Source:</b>	AAIB Field Investigation

Whilst in the cruise at 110 kt the helicopter suddenly pitched nose-down to approximately 30°. The commander immediately applied aft cyclic and lowered the collective lever; this re-established level flight at 80 kt. A gentle handling check confirmed that the cyclic and yaw controls were functioning normally. As the aircraft was only 3 minutes from its intended destination - (Turnberry), the commander elected to continue at 80 kt. During a wide, curved approach to land unusual vibrations were felt through the airframe and as the helicopter approached the hover, a member of the ground crew indicated to the commander, by means of hand signals, that the helicopter should not land since they had observed something unusual about its appearance. The commander then established the aircraft in a high hover to the left of the landing site, whereupon the ground crew member then indicated that an immediate landing should be made. At this stage, eyewitness reports confirmed that the left side horizontal stabiliser detached from the helicopter and fell to the ground. The helicopter was landed immediately and shutdown, with no injuries.

The horizontal stabiliser on this helicopter type consists of left and right aerofoil sections which are attached to a tubular steel spar passing through the tail boom. The spar is attached to the tail boom by means of bolts which pass through forks mounted on either side of the boom, and through horizontally orientated spacer tubes welded across the diameter of the spar. The failure had occurred in the spar at the inboard end of the left stabiliser, and was in the plane of the spacer tube. The diagram at Figure 1 shows the attachment details, and a photograph of the failure is included at Figure 2.

The spar was later subjected to a metallurgical examination which confirmed that the failure was due to high cycle fatigue. There were multiple origins in the heel of the weld around the outboard part of the circumference of the aft end of the spacer tube. The fracture had then progressed forward around the spar's upper circumference and then more rapidly across the forward end of the spacer tube. A region of ductile overload failure was evident around the lower circumference. It was concluded that the failure had probably resulted from in-service vibration causing fatigue in the weld.

The spars, which are not serialised and are not subject to a finite life, had been the subject of a Service Bulletin (No 05-06) issued by Aerospatiale (now Eurocopter) in the form of a Telex on 8 October 1981. This stated that there had been three cases of fatigue failure in the component, Part No 360A13-0012-01, caused by crack initiation at the bead weld of the spacers/spar tube junction, and that dye penetrant inspection was required within the next 10 flying hours and at 50 hour intervals thereafter. In June 1982, the French Airworthiness Authority (DGAC) mandated the Telexed Bulletin by issuing Airworthiness Directive (AD) 82-80-12(B). The Master Servicing Recommendations (MSR) were amended by the manufacturer to reflect the 50 hour inspection requirement. Note: The MSR contains the manufacturer's minimum servicing requirements for the aircraft, and forms the basis from which an operator prepares a Maintenance Schedule.

Eventually, the aircraft manufacturer introduced an improved spar, Part No 360A13-0012-03, with improved weld penetration, and which was not subject to the 50 hour inspections. However, following the accident to G-PLMI, it became apparent that the relevant page of the Illustrated Parts Catalogue (IPC) had never been updated. Despite successive revisions to the IPC, the quoted part number for the spar retained the -01 suffix, with no alternatives listed.

The operator had purchased the helicopter from the manufacturer in July 1995, when it had accumulated 1,213 operating hours. Prior to the sale, the manufacturer had completely refurbished the aircraft and supplied documentation indicating that all Service Bulletins, both Imperative and Recommended, together with all Airworthiness Directives, had been complied with.

In April 1997 some wear was observed in the horizontal stabiliser spar/tail boom fitting attachment and it was decided to replace the spar. A new item was ordered from the manufacturer's UK agent; however the lengthy delivery time quoted forced the operator to search elsewhere for this component. One was subsequently obtained locally from a subsidiary company of a former operator of this type of aircraft. In fact this operator had earlier passed their Maintenance Manual to G-PLMI's new owners, who had copied it to use as their own. This made no mention of 50 hour inspections on the horizontal stabiliser spar tubes as ADs are controlled on "out of phase" inspections. In any event, the aircraft to which the document had originally applied were equipped with the latest -03 spars, with the associated MSR noting that the AD 82-80-12(B) was not applicable by part number.

When G-PLMI's current operator had removed the spar tube, which would have been to the latest -03 standard, the part number was reportedly not visible. Reference to the latest revision of the IPC indicated only one possible part, ie the -01 spar tube, and accordingly this part number was ordered both from the manufacturer's agents and the former SA365C1 operator's subsidiary. The latter organisation, in their capacity as parts distributor, released the component (described as 'serviceable') to their customer on a Certificate of Conformity. However, they had to obtain the part from their parent organisation, which had passed it on together with a JAA (Joint Airworthiness Authority) Form 1. The 'remarks' box on this form referred to an Inspection Report which, subsequent to the accident, could not be found by the releasing organisation. It was thus not established whether any associated reference had been made to the AD. There was no history card with the component.

The manufacturer's UK agent similarly had no information in their system indicating an alternative to the -01 spar (although the -03 component was listed, if this was the number specified in an enquiry), when G-PLMI's operator attempted to order a replacement spar. In fact the order was left with the agent who, as a result of having no spars in stock, ordered one direct from the aircraft manufacturer. When it eventually arrived it was of course a -03 component. This was subsequently fitted to G-PLMI following this accident.

It is probable that the former SA365C1 operator had removed the subject spar tube from an aircraft when the improved components became available from the manufacturer, and which did not have the imposition of the 50 hour inspection. It is thus possible that it had been in storage for up to 1415 years.

The aircraft manufacturer has been informed of the anomalous situation with regard to the IPC.