

CREW STATEMENT

AIA [REDACTED]

05/13/2021

On May 10 & 11, 2021 I, [REDACTED], was assigned a 1600-2400 shift for NVG training with a student. At approximately 1230 hours on May 11, 2021, I received a phone call from CDO [REDACTED] regarding the need for an instructor for [REDACTED] on May 12, 2021. It was determined by the CDO and myself that the best training plan for the student was to schedule 2 flights on May 12, 2021 and that I would flex my schedule to work a 1200-2000 shift to accommodate the training needs as required.

On May 12, 2021 I, [REDACTED], arrived at the hangar for duty at approximately 1130 hours for a 1200 – 2000 shift. At approximately 1200 hours, I researched weather and input my flights into the SMS and TOMIS systems. Weather was reporting northerly winds with ceilings of approximately 2300 feet. Shortly thereafter, I called the CDO, [REDACTED], and conducted a mission brief with him regarding my scheduled flights for the afternoon with my assigned student, [REDACTED]. 2 flights were scheduled. The first flight was intended to be focused on non-standard maneuvers (Emergency Procedures) and the second flight was intended to be focused on instrument flight and maneuvers.

At approximately 1230 hours I met with [REDACTED] in the classroom and began prepping for the flight with him. We started with general questions about fitness for flight and transitioned into some basic oral knowledge questions followed by some hypothetical scenario-based questions prior to the mission. At approximately 1330 hours we took a break and planned to meet at the aircraft at 1345 hours for pre-flight. I checked the aircraft forms and records and calculated the aircraft weight and balance and determined that the aircraft would remain within CG for the duration of flight.

At approximately 1345 hours, we conducted a pre-flight of the aircraft. After determining that the aircraft was airworthy, at approximately 1400 hours, we requested maintenance's assistance with towing the aircraft outside of the hangar to prepare for launch.

At approximately 1415 hours, we buckled in and performed a crew brief. The plan was to depart from KOKC – KRCE and conduct the training flight at KRCE. Once the flight was complete we would return to KOKC for re-fuel.

At approximately 1430 hours, we cranked the engine on N841BP. During the run-up I continued to ask [REDACTED] about applicable systems and limits that coordinated with the run-up prior to takeoff.

At approximately 1450 hours, we (N841BP) departed VFR from KOKC to KRCE.

At approximately 1500 hours, we (N841BP) arrived at KRCE and began training in the NE corner of the airfield to the confined area used for training. After executing the steep approach into the confined area, I requested a hover power check which was approximately 60% TQ. I then requested [REDACTED] to perform a simulated max performance takeoff to depart the confined area and reposition to the platform over the SE corner of the airfield (simulated pinnacle).

After executing the pinnacle landing, (termination to a hover), I demonstrated an iteration to explain the difference between arriving at the intended point of landing "short," thereby requiring more power to

affect an OGE hover prior to landing and expecting IGE Late by planning to arrive over the intended point of landing such that the aircraft arrives in an IGE Hover at the appropriate power setting. [REDACTED] is returning to Sierra Vista, AZ where there is a lot of mountainous terrain and power management needs to be a constant consideration). Prior to takeoff from the pinnacle, I reviewed the importance of accomplishing an altitude over airspeed type of takeoff so that the tail boom would clear the platform.

After the takeoff, and joining a right downwind for 35L, (no other aircraft were in the pattern) I simulated a tail rotor control failure with a high-power setting. [REDACTED] diagnosed the malfunction and executed the procedure appropriately. After landing the crew remained in L closed traffic for RWY 35L.

On the next traffic-pattern I simulated a main-servo-slide valve seizure. [REDACTED] again, responded appropriately and executed the maneuver to proper termination. While on the ground, and prepping the aircraft for takeoff, I noticed that the hydraulic pressure did not return and the HYDR light did not extinguish for approximately 10 secs. I recognized this as being a little delayed from normal, however, this has been an ongoing issue with the majority of our AS350 fleet at NATC. Our maintenance personnel have spent countless hours on the phone with Airbus and determining that this is not a cause for concern. Approximately 1 year ago, I had an issue with a similar type of AS350B2 aircraft where the push button for the HYD Cutoff Switch was sticky and I could not get the hydraulic pressure to return in the pre-takeoff checks. As a result, I felt that it was prudent to not plan on exercising the use of the HYD Cutoff Switch for the remainder of the flight.

The next maneuver that was conducted was quick stops. I explained the difference between a quick stop maneuver above ETL vs below ETL. We discussed which control input to lead with when below ETL and why to do so. We also discussed that when larger power inputs are made is when it is easier to identify a potential flight control malfunction (ie takeoff or landing). We conducted 3 quick stops (1-above ETL, 1-below ETL, and 1-above ETL). On the last quick stop, the aircraft began to slow as normal and then began to yaw to the left at about 25 feet AGL. I began to talk the student through the maneuver and announced, "forward cyclic we need airspeed". After the aircraft made it to approximately 30 degrees left of centerline, I pushed the cyclic forward and began to fly the aircraft out of the maneuver.

As the aircraft was recovering, the control loads instantly became excessive, and I noticed that the HYDR Light on the Caution Panel was illuminated. I announced, "DON'T FIGHT ME ON THE CONTROLS I HAVE THE AIRCRAFT! PUT THE HYDRAULICS BACK-ON!!!" [REDACTED] reached for the HYD Cutoff switch; however, the hydraulic pressure was never restored. After the first revolution in the left-hand spin, the cyclic was pushing against my control inputs with driving to the rear accompanied by a right roll causing erroneous pitch excursions and the collective dropped to the full-down position. It took all my strength to keep the aircraft from smacking into the ground and pedals had no affect on heading control. Despite my efforts for a successful landing the aircraft continued to build an elliptical left yaw until the point of impact. Just prior to impact I pulled all remaining collective that I had the strength for. From what I can recall, the aircraft touched down in a nose low attitude with a right lateral drift while yawing to the left. After impact I believe the aircraft rolled several times to the right until it came to rest on the right side of the aircraft. After coming to rest, I remember looking at [REDACTED] and asking, "Are you okay?" He replied that he was okay and asked me if I was okay. I saw smoke and smelled fumes and knew that

we needed to egress the aircraft. I wasn't sure if [REDACTED] was pinned or able to get out. I unbuckled and began to kick the windscreen on his side with minimal success. The only way out was up through my door which was missing and provided an egress point. I looked at [REDACTED] who was still buckled inside the aircraft and I said, "CUT OFF THE FUEL AND LET'S GET HER SHUT DOWN!!! FIRE WE ARE ON FIRE, WE GOTTA GET OUT OF HERE!" I asked him if he was pinned, and he assured me that he wasn't. He unbuckled and we both climbed out of the left side the aircraft which was the upright side. We were able to connect outside the aircraft and get upwind from smoke and fumes.

At approximately 1527 hours, I called the radio room and let them know that we were involved in an accident but were okay.

At approximately 1529 hours, I called [REDACTED] to advise him of the same.

At approximately 1531 hours, I called 911.

At approximately 1535 hours, I called my wife.

At approximately 1538 hours I called the [REDACTED].

At approximately 1603 hours, both crew members were transported via ambulance to OU Medical Center.

At approximately 1635 hours, both crew members arrived at OU Medical Center.

At approximately 1800 hours, both crew members were discharged from OU Medical Center.