



NTSB RECORD OF CONVERSATION

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Date: 04/10/2018
Person Contacted: Mark Farrell (FAA)
NTSB Accident Number: GAA18CA179

Narrative:

The following is a summary of an email that occurred with the FAA inspector who did an onsite visit:

- He and an airworthiness inspector drove to Haverhill, NH to visit with Mr. Lynn Perry at his hangar
- During the site visit, they observed removal of several cowls and panels to allow visual access of the rotor control linkages. Aircraft was in an enclosed hangar with adequate heat and light. The main rotor had been removed previously, and the tail assembly, which had been torn off in the accident, was lying next to the aircraft. The sliding spline shaft of the starter drive shaft was disconnected and the bearing connection for that shaft was slightly lifted forward. One wire of the roto tach pickup was pulled out of the quick-connector.
- Mr. Perry walked them through the chain of events leading up to the accident and demonstrated the control inputs. The rotor head moved freely in all directions with no evidence of binding or restriction. Mr. Perry removed the access covers below the control columns. No discrepancies were noted with the torque tube or cabling in the keel tube.
- Mr. Perry energized the electrical system and activated the pneumatic system, running through both the GROUND braking activation and the FLIGHT trim modes and travel. The control column and subsequently rotor head reacted appropriately to all inputs. Of interest was the amount of resistance to displacement exhibited by the control column when trim is active.
- Mr. Perry's description of his takeoff procedure was in accordance with the pilot operating handbook. FLIGHT mode needs to be activated to allow the pre-rotator to engage. After the rotor was up to speed (~200 RPM) the control column was moved aft with no resistance noted.



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- Inadvertent and unnoticed activation of full aft trim prior to beginning the takeoff roll could create enough resistance that, coupled with startle and surprise, might be enough to create the conditions Mr. Perry experienced.
- During the accident flight, after noticing the apparent control malfunction, Mr. Perry rapidly reduced power resulting in the nose of the aircraft coming back down, and since it is normal to have some right rudder input applied at this point, the nose wheel would have been angled to the right when it contacted the pavement. At an assumed speed of 40-50 kts, the resulting rollover would have happened quickly.
- Thought the outside air temperature was reported at 29° F, the interior was warmer. Mr. Perry stated he was not wearing gloves and didn't think it likely that he could have inadvertently activated the trim in that manner.
- They moved the brake/trim in various sequences and control positions but there weren't any revelation or other ideas.

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