



MEMORANDUM FOR RECORD

Stephen Stein
Aviation Accident Investigator
National Transportation Safety Board
Office of Aviation Safety – Western Pacific Region

NTSB Accident Number: WPR20LA029
Aircraft Registration & Make/Model: N271HC; Agusta 109SP
Accident Location: Spanish Fork, Utah
Accident Date: November 12, 2019

Note: The following interview was documented by the Investigator –In-Charge (IIC), Stephen Stein.

Interview #1 Summary

Dan Lindberg
Accident Pilot

Interview Date & Time; December 1, 2019, 1012 PT

Mr. Lindberg reported that he a night shift on the day of the accident. He arrived about 1830, performed a preshift briefing, checked weather, and other preflight duties. For the first flight he departed with two nurses onboard to an accident scene in Spanish Fork. During the flight a flight nurse who normally rode in the rear cabin was riding in the left seat of the cockpit with the pilot. The front seat nurse crewmember typically inputs coordinates and corresponds with ground crews. This nurse was not familiar with the avionics, so the pilot helped him load the coordinates a couple of times. The flight to the accident site was about 22 minutes. As they approached the site the nurse attempted to use the radio to contact the ground crew, but the radio was not adjusted correctly. Mr. Lindberg stated that he adjusted the radio to the correct frequency, but in one sudden movement the helicopter suddenly lurched to the left, but the pilot immediately corrected the movement and returned the helicopter to straight and level flight. The pilot reported that the yaw felt like it was about 45°, but the data shows that it was a lot less severe, 11°. He did not observe any unusual vibrations or difference in the flight controls as the rest of the flight and

subsequent flights that evening were all uneventful. This was also that nurse's last flight with him that evening.

After they landed at the site they prepared the helicopter to receive the patient with a preflight inspection, but did not observe any damage. Mr. Lindberg stated he did use a flashlight during his inspection, which involved inspecting for leaks, oil puddles, secure panels, and the structure of the aircraft. He also runs his finger along the leading edges of the tail rotor blades. The structure inspection involves inspecting the wire strike protection, cable, doors, windows, leaks, and anything that looks abnormal. He further remarked that they do a preflight before every flight that includes the non-primary caregiver and himself and that there may be areas they don't inspect.

The pilot stated that they flew several flights after the accident with two additional crewmembers on most of the flights and did not observe the damage until they parked the helicopter at the operator's base at the conclusion of the last flight and the incoming pilot caught the damage.

Interview #2 Summary

Dan Lindberg
Accident Pilot

Interview Date & Time; June 22, 2020, 1215 PT

According to Mr. Lindberg, he normally contacts the communications center who provides an update on aircraft status and changes to daily status report (NOTAM changes, shortages, and crew related concerns). The crewmember briefings are scheduled at 0715 or 1915 each day. During briefings the crewmember from the base assigned for that flight will come to the crew quarters for the briefing, which covers weather, aircraft, and the individuals. They discuss current weather conditions and forecasts, aircraft maintenance items, fuel quantity, and individual issues such as head colds. He added that he doesn't normally break out personal issues individually, but the crewmembers talk and are aware of personal influences in each others lives. The assumption is if there is a personal issue, someone will know about it. On the day of the accident if the nurse who was seated in the cockpit had personal issues he was experiencing they would have known about it and Mr. Lindberg did not recall there were any concerns about that nurse on the day of the accident. The crew typically will chime in on personal issues and the pilot expected his crew to speak up if they have a personal or human factors issue.

The pilot also stated that the company does not have any issues or place any pressure on its crew to take flights. Prior to departure they use a risk assessment known as SLEEPY. After the briefing the pilot will inform the communication center of the risk and they will assign a number. If risks are below a certain level, the pilot and crew can decided whether to take the flight. The circumstances of the accident flight were at this level. However, if the risks are higher then the crew needs to consult another pilot and if the risks exceed another level then management gets involved.

The briefings also allow crewmembers to express their feelings and comfort levels and needs. The pilot also completes an operations compliance form. The accident pilot reported that he would have covered the areas of the operator's PEOPLE acronym in his briefing.



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Interview #1 Summary

Ian Hess
Flight Nurse

Interview Date & Time; June 25, 2021, 1333 PT

Mr. Hess stated that he started with Intermountain in June 2008 and had worked in the children's ICU for about 13 years and had worked in life flight for about 6 years when the accident occurred. He had worked with the pilot and the other flight nurse for about 5 years at the time of the accident; he flew with the pilot frequently and had only flown with the other flight nurse about a dozen times. According to Mr. Hess, given his previous experiences with the pilot, they would have briefed at the beginning of the shift that night prior to the flight, which would have covered health issues, if each crewmember felt rested, equipment, weather, plan. He did not remember the briefing on the night of the accident.

The flight nurse reported that he always flies on the Agusta 109SP and that there is always a flight crewmember in the cockpit with the pilot when flying without a patient. Usually the primary flight nurse will sit in the rear cabin. Mr. Hess stated that for each flight there is a pilot and 2 nurses or 1 nurse and a paramedic. He is in the back about 50% of the time and always paired up with an adult nurse or neonatal nurse. The other nurse sat in the cockpit on the night of

the accident because he as the non-primary caregiver. Mr. Hess stated that he did not remember observing any unusual behavior on the night of the accident from the pilot or other flight nurse. He further remarked that he would have remembered if either of the flight crew were affected by something personal.

According to Mr. Hess, the other flight nurse was in the left seat in the cockpit and the pilot was in the right seat and Mr. Hess was in the rear cabin forward facing seat. They were responding to a location about 20 minutes away and the other nurse was attempting to reach the EMS crew on the ground to get landing zone information. At the time he was trying to push the radio activation button, but pushed the pedal instead, which made the helicopter jerk. The pilot then told the other nurse not to push the pedals and the nurse apologized. Mr. Hess stated that he did not hear any impact noises or anything to indicate that the tail rotor had contacted the tail boom at the time. According to Mr. Hess, the other nurse was a large lean build and figured he may have “given it too much.”

Mr. Hess reported that he had never personally pushed the pedal by accident when attempting to use depress the push-to-talk switch, but heard that it happens occasionally. Before the accident flight he would actively think about his foot position to ensure his foot did not inadvertently contact the pedals during night flights only. Prior to each flight he does a walkaround inspection of the helicopter. He begins with the left tail, checks the tail rotor, lights, panels, baggage door, left sliding door track, front door, nose pitot tube, wire cutters, pilot side GPU door closed, fuel door closed, and back to the tail. He uses a flashlight if there are no landing area lights. From what he remembers the tail rotor blades usually end up blocking out to the empennage so may have been hard to see the damage.



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Interview #1 Summary

Mark Gunty
Flight Nurse

Interview Date & Time; December 4, 2019, 1900 PT

Mr. Gunty reported that at the time of the accident he had been a critical care nurse for 25 years, and a flight nurse for about 11 years. He started working for Intermountain, the helicopter operator, in the Fall 2014 and had flown on the AW109SP and the AW109K2. He stated that about 90% of the time he sat in the rear cabin of the helicopter (not in the cockpit). Mr. Gunty stated that he works about 36 hours each week, primarily at night. He had no flight experience at the time of the accident.

On the day of the accident he was scheduled to work a 12 hour shift. He reported that evening at 1830 and had been off that day. The accident took place during his first flight of his shift after they received a call about a 15 year old trauma patient who was classified as a pediatric patient and whom they paired with a pediatric nurse. Mr. Gunty, the adult nurse, rode in the cockpit and the pediatric nurse rode in the rear cabin for this flight. The departure and flight was uneventful until they were about 13 minutes out. Mr. Gunty was attempting to reach the ground crew at the landing zone to determine where they were supposed to land. The flight nurse seated up front

will also input the GPS coordinates. This is usually done at the request of the pilot. Mr. Gunty input the GPS coordinates with assistance from the pilot who talked him through the process since Mr. Gunty doesn't perform this function regularly. Mr. Gunty further remarked that he wasn't familiar with the GPS despite receiving training on the unit a couple of times each year because it's not a regular part of his job. During the accident flight he struggled with its use and the pilot had to show him which buttons to press. The pilot had asked Mr. Gunty to input the coordinates and the nurse recalled that the pilot had to tell him "no, it's the top button" because Mr. Gunty did not know which button to start with. Mr. Gunty stated that once he reached the page where he could input the coordinates there were no further issues.

Mr. Gunty then attempted to contact the ground crew a few times using a handheld radio that's connected to the helicopter's push to talk switch. This handheld is preprogrammed and the person in the rear cabin can toggle between ground frequencies. On the night of the accident Mr. Gunty attempted to contact the ground crew, but was unable to reach them initially. Eventually he was able to reach them and started to obtain the ground conditions. He usually activates the radio microphone by dragging his foot down the rail on the left side of the foot well and finds the switch. As they were flying and he was trying to reach them he went to press the button, but his foot caught the corner of the left pedal and he pushed down on the pedal, which caused the helicopter to abruptly tilt left at a slight nose down angle. Mr. Gunty immediately lifted his foot off the pedal; the pilot immediately corrected the movement and placed the helicopter back on its original flight path. The entire movement felt like they got hit with strong turbulence over a mountain. The pilot's correction felt like the helicopter moved up and back to the right. According to his recount the pilot responded promptly. Mr. Gunty did not observe any unusual vibration, noise or abnormal functions with the helicopter after the event. The rest of the flight was uneventful.

Mr. Gunty reported that they always do a walkaround inspection with the pilot unless they are tending to the patient. He specifically focuses on the wire cutters, ensures doors are shut, but doesn't inspect the helicopter blades, or tail rotor blades as these are part of the pilot's inspection routine.