Aircraft Accident Investigation Board, Norway HSL

REPORT

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REP: 60/2002
Date: 23 October 2002

All times given in this report is local time (UTC + 2 hrs.), if not otherwise stated.

Aircraft	
-type & reg.:	Cessna 180H, OH-CEX
-year of man.:	1967
-engine:	Teledyne Continental 0-470-R
Date and time:	18th of April 2002 at 1400 hrs
Location:	Rakkestad, runway 33, Norway
Type of occurrence:	Accident during takeoff. Aileron cross coupling.
Type of flight:	Private, testflight following major overhaul.
Weather cond.:	Wind 60°, 5-10 kts. CAVOC. Temp. 10°C.
Light cond.:	Daylight
Flight cond.:	VMC
No. of persons onb. :	1
Injuries:	None
Aircraft damage:	Major on wings, landing gear, engine and fuselage.
Other damage:	None
Commander	
-sex/age:	Male , 61 years
-licence:	PPL-A
Information sources:	Pilots report and AIB-N investigation.

SUMMARY

The aircraft had been totally rebuilt at the repair shop after an accident on a lake in Finland in 2001. The aircraft had been sold to a new owner, who also was present at this handover from the repair shop. This was the first test flight after the rebuild and the previous owner performed the flight. A CAA inspector from Finland witnessed the flight. The wind was 90° to the field and since the airfield has a slope, the pilot decided to take off downhill (field 33). After having run the engine he accelerated down the field. At 30 kt he lifted the tail and at 50 kt he lifted off. In order to compensate for the side wind he used right aileron. This resulted in a lift of the right wing, which the pilot believed was wind induced and therefore he used more aileron. At this point the aircraft was 5 – 10 m up in the air. The aircraft continued the roll to the left and the wing struck the ground. The aircraft spun twice on the ground before it came to a rest approx 200 m from the edge of the runway up in a

slope 30 m to the left of the shoulder. The pilot, who was not injured, believed there had been a cross coupling of the left and the right aileron.

COMMENTS FROM THE ACCIDENT BOARD

The AIB inspected the wreck and confirmed that a cross coupling between the right and the left aileron had taken place. This is the classical occurrence that cannot happen. The aircraft had been in the hangar for months. Many of the mechanics working in the hangar have probably been moving the aileron without observing the mismatch. The mechanic that did the job inspected it and signed it off and an inspector at the repair shop checked it and signed it off. The CAA inspector inspected it without comments, but he had not yet approved it. Both at the daily inspection and during pre-flight inspection the pilot is obliged to check the control surfaces and their movement accordingly with the control wheel movement. Nobody noticed the direction of movement, only that there where connection and free movement in both directions. Based on the paperwork and interview with key personnel at the repair facilities, the work has been performed according to approved standards and internal procedures.

Let this be a remainder that inspection - at all levels - also is to confirm correct operation, not only operation performed.