RESPONSES RECEIVED ON DRAFT REPORT: 'LOSS OF CONTROL, HÉLICOPTÈRES GUIMBAL CABRI G2 HELICOPTER, LELYSTAD AIRPORT'

Reading guide: The fourth and fifth columns provide the literal text of the responses of the parties. The last column contains an explanation from the Dutch Safety Board of the way the responses were processed.

No.	Organisation	Section	Text to be corrected (first last word)	Argumentation for response	Adopted?
1	IenW	1.3		Onduidelijk is of de data van het Aviation Safety Network gezien kan worden als een betrouwbare en bruibare bron. Op de website van het ASN staat namelijk dat de door de organisatie bijgehouden "ASN accident database" geen helikopter voorvallen bevat. Deze voorvallen staan in de "ASN wikibase" dit betreft een open source database met updates vanuit de user community. Translation Dutch Safety Board: It is unclear whether the Aviation Safety Network data can be seen as a reliable and useful source. The ASN website states that the "ASN accident database" maintained by the organization does not contain any helicopter incidents. These incidents are listed in the "ASN	No
2	lenW	2.5.2		 Onduidelijk is of de data van het Aviation Safety Network gezien kan worden als een betrouwbare en bruikbare bron. Op de website van het ASN staat namelijk dat de door de organisatie bijgehouden "ASN accident database" geen helikopter voorvallen bevat. Deze voorvallen staan in de "ASN wikibase" dit betreft een open source database met updates vanuit de user community. Translation Dutch Safety Board: It is unclear whether the Aviation Safety Network data can be seen as a reliable and useful source. The ASN website states that the "ASN accident database" maintained by the organization does not contain any helicopter incidents. These incidents are listed in the "ASN wikibase", which is an open source database with updates from the user community. 	No
3	lenW	3.6		De enige "lesson learned" is in deze toegeschreven aan de vlieger. Onduidelijk is waarom er geen "lessons learned" zijn vastgesteld voor de andere betrokkenen, waaronder ATC. Een van de causale factoren voor de root cause van dit voorval is immers de (tweemaal) afgegeven incorrecte ATC instructie. Translation Dutch Safety Board: The only "lesson learned" in this case is attributed to the pilot. It is unclear why no "lessons learned" have been identified for the other parties involved, including ATC. After all, one of the causal factors for the root cause of this incident is the incorrect ATC instruction issued (twice).	Yes
4	lenW		ICAO, Doc 9432 AN/925, Manual of Radiotelephony, 2007.	Ook EU Verordening 923/2012 SERA geeft onder artikel SERA.14045 in tabel S14-4 de betekenis van de termen "CONFIRM" en "SAY AGAIN". Translation Dutch Safety Board: EU Regulation 923/2012 SERA also provides the meaning of the terms "CONFIRM" and "SAY AGAIN" under article SERA.14045 in table S14-4.	Yes

APPENDIX B

Dutch Safety Board response
The source is used as an indication, not as a factual substantiation.
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An incorrect ATC instruction is part of the context that can lead to confusion in some situations. Several parties involved can learn lessons from this. The Board adjusted the text accordingly.
The Board adjusted the text accordingly.

No.	Organisation	Section	Text to be corrected (first last word)	Argumentation for response	Adopted?
5	HeliCentre	2.1	The combinationyaw axis	 Heeft niks met het incident te maken. Zou wellicht beter omgezet kunnen worden dat de effectiviteit van de staart minder is met een Fennestron bij lage snelheid (in combinatie met hoge collective setting). Je zou eens in Airbus inforation notice No. 3539-I-00 kunnen kijken voor meer info. Wij geven eens in de zoveel tijd ook een safety newsbrief uit. Voor de volgende editie heb ik een stukje over unanticipated yaw geschreven met als bron de safety notice van Airbus. Zelf vind ik dat hier met minder tekst veel meer info wordt gegeven dan dat Guimbal dat doet. Translation Dutch Safety Board: Has nothing to do with the incident. It might perhaps be better to translate the fact that the effectiveness of the tail is less with a Fennestron at low speed (in combination with a high collective setting). You might look at Airbus information notice No. 3539-I-00 can be found for more information. We also publish a safety newsletter every now and then. For the next edition 	No
				I wrote a piece about unanticipated yaw, using the Airbus safety notice as the source. I personally think that much more information is given here with less text than Guimbal does.	
6	HeliCentre	2.5.1	Service Speed	De service letters staan er 4 in. Wordt er niet bedoeld dat het pagina 4 en pagina 26 zijn? Ik kan SL 12-0014 en SL190026 niet vinden.	Yes
				Translation Dutch Safety Board: The service letters are 4 in it. Isn't it meant to be page 4 and page 26? I can't find SL 12-0014 and SL190026.	
7	HeliCentre	2.5.3	A pedal	Volgens mij (even uit mijn hoofd) ging dit incident over een Cabri die juist over rechts draaide. Maar in de alinea wordt gesproken over de gevoeligheid van de left yaw.	No
				Translation Dutch Safety Board: I think (just off the top of my head) this incident was about a Cabri that turned to the right. But the paragraph talks about the sensitivity of the left yaw.	
8	BEA/Guimbal		rudder pedals	We suggest yaw pedals	Yes
9	BEA/Guimbal		If in this situation a left turn is started, additional power will be needed to stop the left turn. This power may not be available and could cause the helicopter to rotate around its yaw axis.	We suggest deleting these phrases. About piloting and technical aspect, there is no link with event. This is only applicable if full power is already used by the main rotor, which is not possible because the aircraft was descending.	No
10	BEA/Guimbal		SL 12-0014 SL 19-0026	We think that there is confusion with possibly the chapter inside the SL. There are no SL 12-004 and SL-190026, we suggest deleting these terms. SL 12-0014 and 19-0026 do not exist, only SL 12-001 and 19-002	Yes
11	BEA/Guimbal		QNH 1043	If you can confirm the QNH, we have a doubt. Although it is not relevant for the incident.	No
12	LVNL		Due to the distraction, the pilot allowed the airspeed to drop to zero knots, while the helicopter climbed about 600 feet, without the pilot noticing. Suggestion is to note the distraction as one of the reasons.	The instruction was certainly a distraction for the pilot, however the causal connection between the distraction and the loss of control is too strongly worded, giving the impression that this was the sole factor. In reality, many more factors were likely at play in this event (stress, approaching circuit, helicopter type, low experience hours, control of the tail rotor practice, other aircraft in the circuit, etc.) that forms the complete picture.	No
13	LVNL		The pilot expected the instruction to fly a left hand downwind Runway 05 and asked the air traffic controller to "repeat" the instructions.	Apparently the pilot, by using non-standard R/T, did not challenge the instruction, leading the control to simply repeat the instruction.	No

Dutch Safety Board response
Both the required power (OGE hover) and the Fennestron tail rotor influence the rotation (yaw) of the helicopter.
The Board adjusted the reference to the Service Letters.
The helicopter in the incident investigated by the BEA turned to the left.
The Board adjusted the text accordingly.
This is a generic explanation of how a helicopter works.
The Board adjusted the reference to the Service Letters.
The QNH is correct according to the report made available by the KNMI.
According to the pilot, the distraction was a factor (context) that had an influence. This does not rule out the influence of other factors, but no indications were found that suggest otherwise.
This comment is in line with the Dutch Safety Board's finding. That is why we have not adjusted the text accordingly.

No.	Organisation	Section	Text to be corrected (first last word)	Argumentation for response	Adopted?
14	LVNL		Figure 1	The figure on this page indicates the pilot had overall difficulty to control the altitude at a steady number. That could provide another clue about the controllability of the helicopter.	No
15	LVNL		The pilot of PH-HCJ had completed a 90-degree left turn in the meantime. During this turn, he noticed on the flight instruments that his airspeed was now almost zero knots.	Only later in the report this left turn is clarified as unintentional. Suggest to add the unintentional (rotor torque) aspect of the turn also to this section.	No
16	LVNL		Besides the air traffic controller, the tower was occupied by a student 27 assistant controller and instructor.	Please clarify it was an instructor controller, not a helicopter instructor.	No
17	LVNL		"Both the tower frequency load and the maximum number of aircraft that were allowed, were close to the issued maximum capacity"	There is no such thing as a maximum number of aircraft allowed. There is also no defined maximum frequency load (the latter would not even be possible, because this data is made transparent afterwards and this is only visible to the air traffic controllers the next working day). Both are guidelines, a guideline (every situation is different). The purpose of making this data available in the form of this feedback is that the existing crew subsequently gains more insight into the workload characteristics of the previous day. This insight can be used in future situations where it could improve decision-making about handling certain (types of) flights.	Yes
18	LVNL		"An incorrect and unexpected instruction from air traffic control caused confusion of the inexperienced pilot which lead to a distraction from flying." Suggestion is to delete the word "incorrect".	A right-hand downwind RWY05 instruction is not something that is necessarily incorrect. If the pilot crossed the field overhead and had gone to a right-hand downwind RWY05, the pilot had followed the instruction correctly. It was an unexpected instruction that lead to confusion of the trainee pilot. The air traffic controller's instruction for a right hand downwind caused the pilot to have doubts - and into an uncontrolled flight. There is quite a lot of attention for this instruction and its consequences, while the Board itself also notes that the student pilot 'partly because of this lost control of the helicopter'. The impression from this draft report is that this helicopter has a built-in control problem that can reveal itself at any time to any (inexperienced) pilot - such as in a more or less unexpected situation like this. The report actually confirms this. The suggestion is to more clearly put the emphasis on this control issue, which was (once again) demonstrated with this incident.	No

Dutch Safety Board response

The Dutch Safety Board has analyzed the flight track and no controllability issue emerged.

The initiation of the left turn was intentional, but the continuation of the rotation was not. This is explained further in the analysis section of the report.

The paragraph talks about air traffic controllers in an air traffic control tower.

The Board adjusted the text accordingly.

In this situation, given the intended circuit procedure, the instruction given was incorrect according to the Dutch Safety Board. That it was an incorrect instruction is also evident from the fact that it was corrected by air traffic control on the second pilot.