



National Transportation Safety Board Aviation Accident Factual Report

Location:	Highgate, VT	Accident Number:	IAD05LA085
Date & Time:	06/26/2005, 1300 EDT	Registration:	None
Aircraft:	Martel Air Command 532Elite	Aircraft Damage:	Substantial
Defining Event:		Injuries:	1 Fatal
Flight Conducted Under:	Part 91: General Aviation - Personal		

On June 26, 2005, about 1300 eastern daylight time, an amateur-built, unregistered Air Command 532 Elite gyroplane was substantially damaged when it impacted trees and terrain in Highgate, Vermont. The certificated private pilot was fatally injured. Visual meteorological conditions prevailed, and no flight plan had been filed for the local flight, which originated at Franklin County State Airport (FSO), Highgate, Vermont. The personal flight was conducted under 14 CFR Part 91.

According to a Vermont State Police report, the pilot's daughter stated that he had purchased the gyroplane (used) about 2 weeks before the accident. As far as she knew, the pilot assembled it himself, and was thinking about modifying it, but had not done so by the time of the accident. She also noted that the pilot was not taking any lessons, and that he was learning to fly it on his own.

Another pilot confirmed with police that the accident pilot had purchased the gyroplane about 2 weeks previously. On June 24, 2006, the accident pilot performed touch and go landings, or "crow hops," along the runway, and on the day before the accident, the accident pilot flew the gyroplane for the first time.

On the day of the accident, a local sheriff was at the airport when he observed the gyroplane, about 800 feet in the air, with "some type of mechanical failure." He then saw the gyroplane "go straight down into [a] heavily wooded area."

Another witness saw the gyroplane take off, and about 500 feet, the "the blade folded," and the gyroplane "went down."

A third witness noticed "the propeller not working," before the gyroplane "went straight down with the front end first," while a fourth witness thought "the rotor was barely moving" before seeing the gyroplane descend vertically.

According to a Federal Aviation Administration (FAA) inspector, the wreckage was located

about 1 mile east of the runway, in wooded terrain. Fuel was found at the scene and in the fuel filter, and the propeller was hand-turned "without difficulty."

According to an FAA-approved basic flight instructor (BFI), the accident pilot had phoned him and asked about lessons, as he was buying a gyroplane. The flight instructor was familiar with the gyroplane, as he had seen it operated at fly-ins by the original owner. He urged the accident pilot to convert it to the manufacturer's then-current approved configuration, using an upgrade kit the manufacturer sold. The flight instructor understood that the accident pilot had acquired the upgrade kit, but elected to fly prior to installing it. The kit lengthened the tail boom and raised the seat to bring the center of gravity in line with the propeller thrust line. The instructor knew of no similar accidents in the upgraded version of the gyroplane, "in contrast to a dozen or more accidents similar to this one in the unmodified originals."

The flight instructor further stated that he was familiar with the accident model of gyroplane because he had owned and flew an earlier model for a number of years. His was lighter, simpler, and a lower-powered version, but its center of gravity was 5-6 inches below the propeller thrust line. He put 300-400 hours on it, but "eventually grounded it because of its pitch stability problems. These qualities made it very unpleasant to fly in even routine thermal turbulence."

The flight instructor also stated to the FAA inspector that the accident model was "very unstable in the best of hands," and that he understood how a novice could have difficulty flying one.

The flight instructor subsequently had an opportunity to examine parts of the wreckage. According to his observations, the vertical main rotor spindle that was attached to a ring gear was bent 25-30 degrees to the left. The ring gear, which spun above the spindle and was normally in a plane parallel to the top surface of the torque bar, was tilted to the left of the top surface of the torque bar.

There were also deep gouges on the front end of the torque bar, which corresponded with the positions of bolts that held the main bearing assembly together. The main bearing assembly would normally rotate just above the torque bar, with the ring gear, and the bolts would clear the bar. Contact between the bolts and the torque bar would have been consistent with violent bending loads having been placed on the main spindle bolt.

The main rotor bearing was not seized and could be spun easily by hand. Except for saw cuts made by the recovery crew, the control pushrods were bent but continuous.

The flight instructor also noted that the propeller thrust line was located 8-10 inches above the center of gravity on the unmodified (accident) model of gyroplane. The horizontal stabilizer was small and close-coupled. If the rotor thrust was interrupted, either by pilot input or a

sharp downdraft while the throttle setting was high, propeller thrust would cause a violent nose-down rotation of the airframe. Such a rotation would then result in a cyclic pitch change to the rotor, overpowering pilot control inputs. Since the rotor spun counterclockwise (from above), there would be a pitch increase to the retreating blade on the gyrocopter's left side. The blade (which already operated at a higher angle of attack than the advancing blade because its airspeed was lower) could then stall if the cyclic pitch input were large and sudden enough. That, in turn, would result in the blade on the left to descend as it proceeded through the left-rear sector of the rotor disk. Such motion, if the rotor flexed down beyond its normal flapping stops, would allow the rotor to contact the propeller and the drive gear for the pre-spin mechanism, as well as potentially bend the spindle bolt to the left or aft. If the stalled blade hit the propeller, it could fold up as seen by the witnesses.

The accident pilot held a private pilot certificate with a single engine land rating. The pilot's latest FAA third class medical certificate was attained on April 4, 1998. At the time, the pilot reported 2,350 hours of flight time. Flight time since that date was unknown. The pilot did not hold a repairman's certificate for the gyroplane.

An autopsy was performed on the pilot by the Office of the Chief Medical Examiner, Vermont State Department of Health, Burlington, Vermont. Toxicological testing was performed by the FAA Forensic Toxicology Team, Oklahoma City, Oklahoma.

Weather, reported at an airport about 25 nautical miles to the southwest, at 1253, included clear skies, winds from 120 degrees true, at 7 knots, a temperature of 84 degrees Fahrenheit, and a dew point of 64 degrees Fahrenheit.

Pilot Information

Certificate:	Private	Age:	66, Male
Airplane Rating(s):	Single-engine Land	Seat Occupied:	Single
Other Aircraft Rating(s):	None	Restraint Used:	Seatbelt, Shoulder harness
Instrument Rating(s):	None	Second Pilot Present:	No
Instructor Rating(s):	None	Toxicology Performed:	Yes
Medical Certification:	None	Last FAA Medical Exam:	04/01/1998
Occupational Pilot:		Last Flight Review or Equivalent:	
Flight Time:	2350 hours (Total, all aircraft)		

Aircraft and Owner/Operator Information

Aircraft Make:	Martel	Registration:	None
Model/Series:	Air Command 532Elite	Aircraft Category:	Gyroplane
Year of Manufacture:		Amateur Built:	Yes
Airworthiness Certificate:	Experimental	Serial Number:	1
Landing Gear Type:	Tricycle	Seats:	1
Date/Type of Last Inspection:	Unknown	Certified Max Gross Wt.:	
Time Since Last Inspection:		Engines:	1 Reciprocating
Airframe Total Time:		Engine Manufacturer:	Rotax
ELT:	Not installed	Engine Model/Series:	532
Registered Owner:	Joseph R. Benjamin	Rated Power:	65 hp
Operator:	Joseph R. Benjamin	Operating Certificate(s) Held:	None

Meteorological Information and Flight Plan

Conditions at Accident Site:	Visual Conditions	Condition of Light:	Day
Observation Facility, Elevation:	PLB, 371 ft msl	Distance from Accident Site:	25 Nautical Miles
Observation Time:	1253	Direction from Accident Site:	230°
Lowest Cloud Condition:	Clear	Visibility	10 Miles
Lowest Ceiling:	None	Visibility (RVR):	
Wind Speed/Gusts:	7 knots /	Turbulence Type Forecast/Actual:	/
Wind Direction:	120°	Turbulence Severity Forecast/Actual:	/
Altimeter Setting:	30.12 inches Hg	Temperature/Dew Point:	29° C / 18° C
Precipitation and Obscuration:	No Obscuration; No Precipitation		
Departure Point:	Highgate, VT (FSO)	Type of Flight Plan Filed:	None
Destination:		Type of Clearance:	None
Departure Time:	EDT	Type of Airspace:	

Airport Information

Airport:	Franklin County State (FSO)	Runway Surface Type:	
Airport Elevation:	228 ft	Runway Surface Condition:	
Runway Used:	NA	IFR Approach:	Unknown
Runway Length/Width:		VFR Approach/Landing:	Unknown

Wreckage and Impact Information

Crew Injuries:	1 Fatal	Aircraft Damage:	Substantial
Passenger Injuries:	N/A	Aircraft Fire:	None
Ground Injuries:	N/A	Aircraft Explosion:	None
Total Injuries:	1 Fatal	Latitude, Longitude:	44.940000, -73.083333

Administrative Information

Investigator In Charge (IIC):	Paul R Cox
Additional Participating Persons:	Ted Domin; FAA/FSDO; Portland, ME
Investigation Docket:	NTSB accident and incident docket serve as permanent archival information for the NTSB's investigations. Dockets released prior to June 1, 2009 are publicly available from the NTSB's Record Management Division at pubinq@ntsb.gov , or at 800-877-6799. Dockets released after this date are available at http://dms.nts.gov/pubdms/ .