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MEDIA RELEASE

PNG ACCIDENT INVESTIGATION COMMISSION RELEASES FINAL REPORT ON HELICOPTER ACCIDENT OCCURRED NEAR BULUMA TOWNSHIP, WEST NEW BRITAIN PROVINCE

The Chief Commissioner of the PNG Accident Investigation Commmission (AIC) Mr. Hubert Namani, today announced that the AIC released to the public a Final Report with regard to the investigation conducted on the helicopter accident occurred on 11th August 2019 near Buluma Township, West New Britain Province.

Mr. Namani explained that *"on 11 August 2019, at 11:25 local time (01:25 UTC), a Bell 427 helicopter, registered P2-HSG, owned and operated by Niugini Helicopters, was reported to have impacted a reef 3.1 nm of North West of Buluma township while conducting a VFR ferry flight from Kokopo, East New Britain Province to Kimbe, West New Britain Province."*

The AIC received a notification about the occurrence on the same day and immediately commenced an investigation in accordance with its mandate under the Civil Aviation Act 2000 (As Amended) and aligned with Annex 13 to the Convention on International Civil Aviation with complete independence from State authorities and aviation service providers.

"According to the pilot, as the helicopter was in a normal descent into Kimbe, at about 3,000 ft, he decided to conduct an autorotation descent exercise to check the autorotation RPM which had been adjusted during an unscheduled maintenance activity the day before. At around 1,000 ft, a low rotor RPM warning activated, and the pilot assumed a failure of one of the helicopter's engines, entering an emergency autorotation descent straight ahead along its planned track and pressing the SOS button on the installed company tracking system and later transmitting a Mayday."

"As the helicopter was getting closer to the water, the pilot realised that engine power was available. However, he concluded that it was already too late to recover and he had also not determined the cause of the warning and abnormal reading. He therefore continued on and ditched the helicopter on the water."

The Final Report concluded that the decision of the pilot to conduct the autorotation RPM check over water, far away from a safe landing area, although not directly casual to the accident, contributed to the severity of the accident.

The Final Report also identified that the pilot's initial misdiagnosis of low rotor RPM warning associated, with the alleged abnormal torque reading led the pilot to enter into the emergency descent instead of actioning the low rotor RPM emergency procedure, and the late recognition of engine status resulted in the pilot being unable to recover from the emergency descent as the helicopter was quite low at that time.

Mr. Namani also explained that *"after the helicopter ditched, it continued tracking towards the South West for about 20 minutes before it reached a shallow reef. The pilot tried to lift the helicopter onto the reef, but it spun out of control, impacted the reef, and then came to rest on its left side.*

"The tail boom was torn off as it impacted the reef with momentum. The main rotor gearbox separated from its mount, only being held by springs, during the impact sequence and lodged itself into the forward lower section where the pilot's foot pedals were located. This injured the pilot's right foot.

"The Operator reported that the CEO received a 'SOS' alert on his phone within 10 minutes of the pilot activating it. He immediately commenced coordination of the rescue operation. Rescuers arrived on scene about 40 - 45 minutes after the accident and rescued the pilot."

The Final Report of the investigation is available on AIC's website www.aic.gov.pg