



EASA/CASIA Annual Meeting 2017

Challenges during the investigation of an accident in Oajevágge, Norrbotten County, Sweden on 8 January 2016 involving the aeroplane SE-DUX of the model CL-600-2B19, operated by West Atlantic Sweden AB.

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Agenda

- The arctic environment
- Priorities and methods at the accident site
- Wreckage recovery
- Stakeholders, planning and coordination
- Analysis of available data
- Visualisation of the event
- Conclusions

CRJ 200 PF

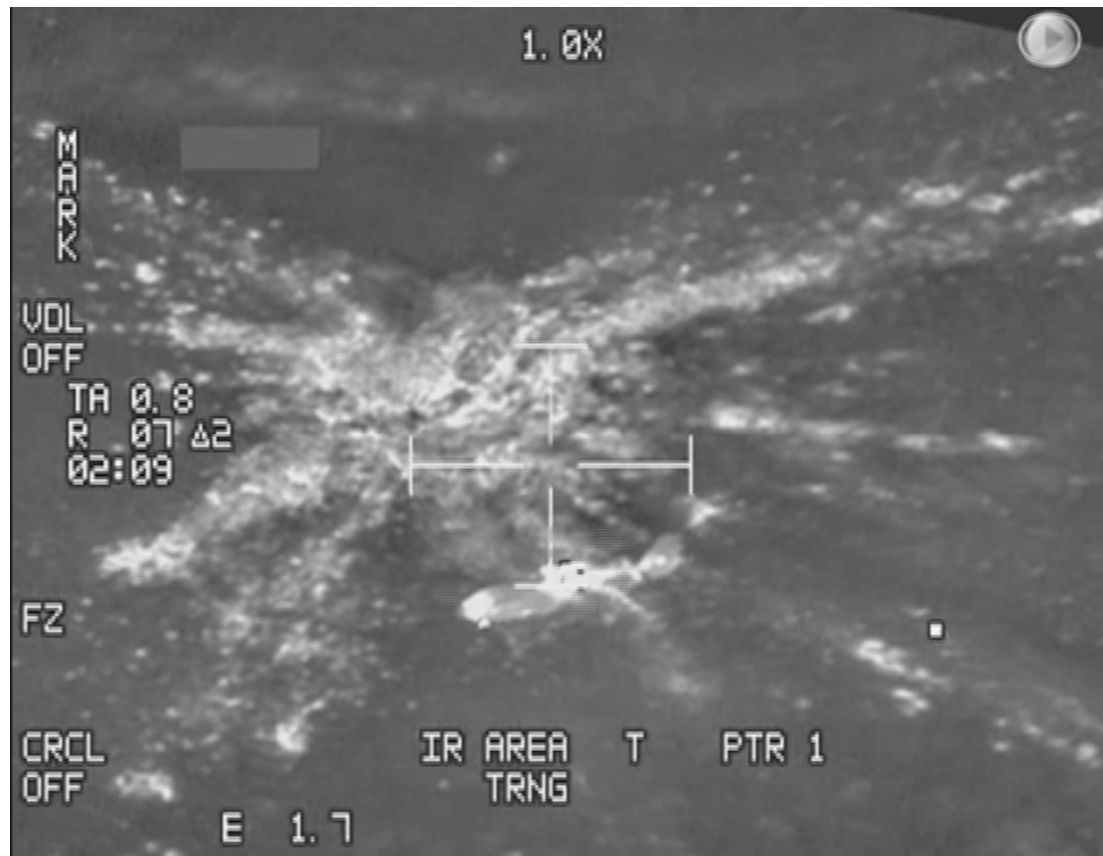


ATC lost contact FL 88



Search and rescue

- 03.07 hrs accident site localised by F16, RCAF
- No chance of survival



Arctic environment - challenges



Meteorological conditions

- - 25°C to - 40°C (- 13°F to - 40°F)
- Wind and wind chill factor (10 kts: - 25°C \Rightarrow - 40°C)
- Sun above horizon 10:50 am to 13:05 pm
- Weather time frame of 2 days
 - Site accessible by helicopter only (20 min flight)
 - Snow covering of site



Challenges

- Communication (satellite phone only)
- Cameras
 - Low battery life
 - Lens condensation
- Deep frozen ground



Top priorities

- Recorders
 - FDR and CVR
- Four corners
 - Eliminate inflight breakup scenario

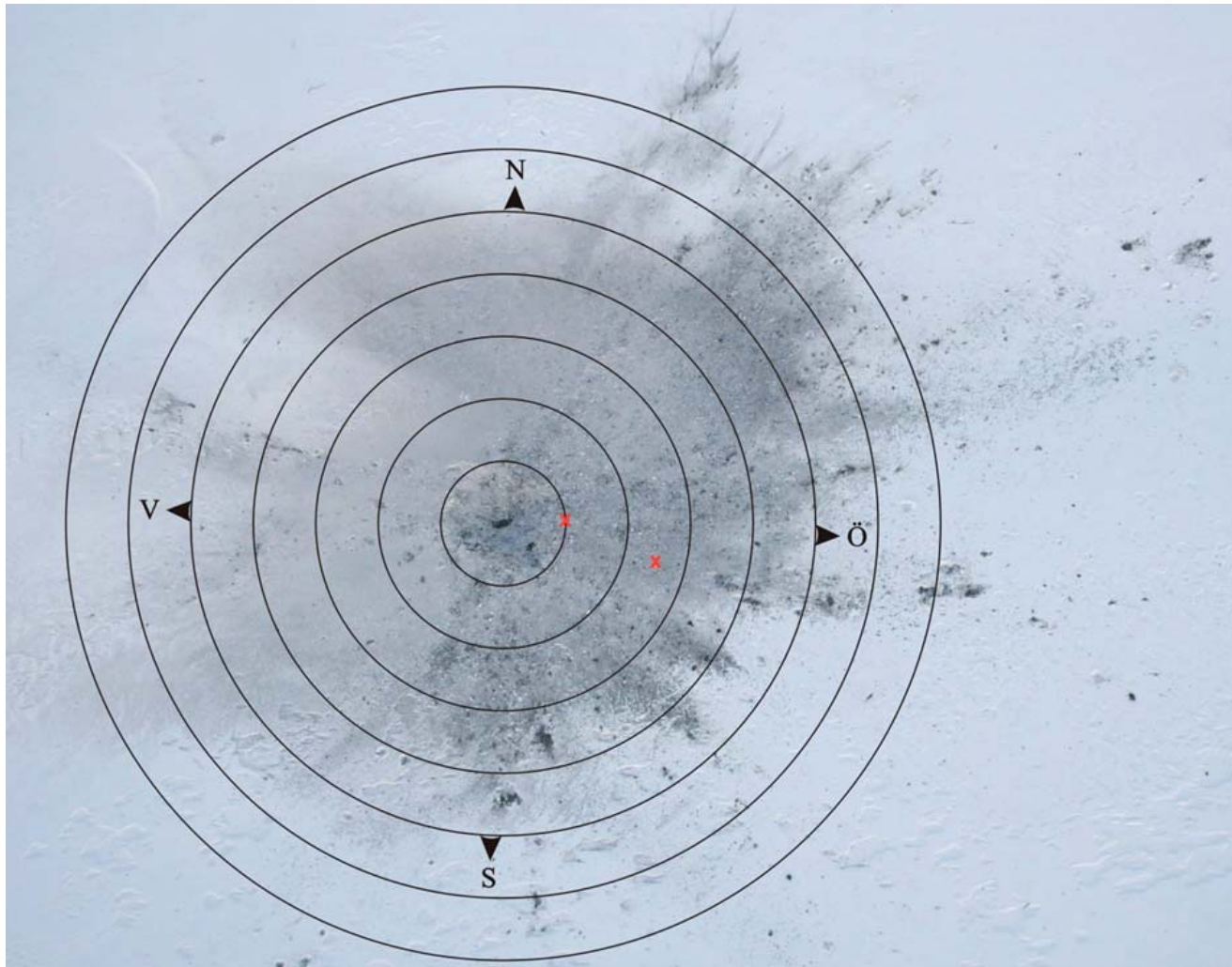
Accident site



Accident site



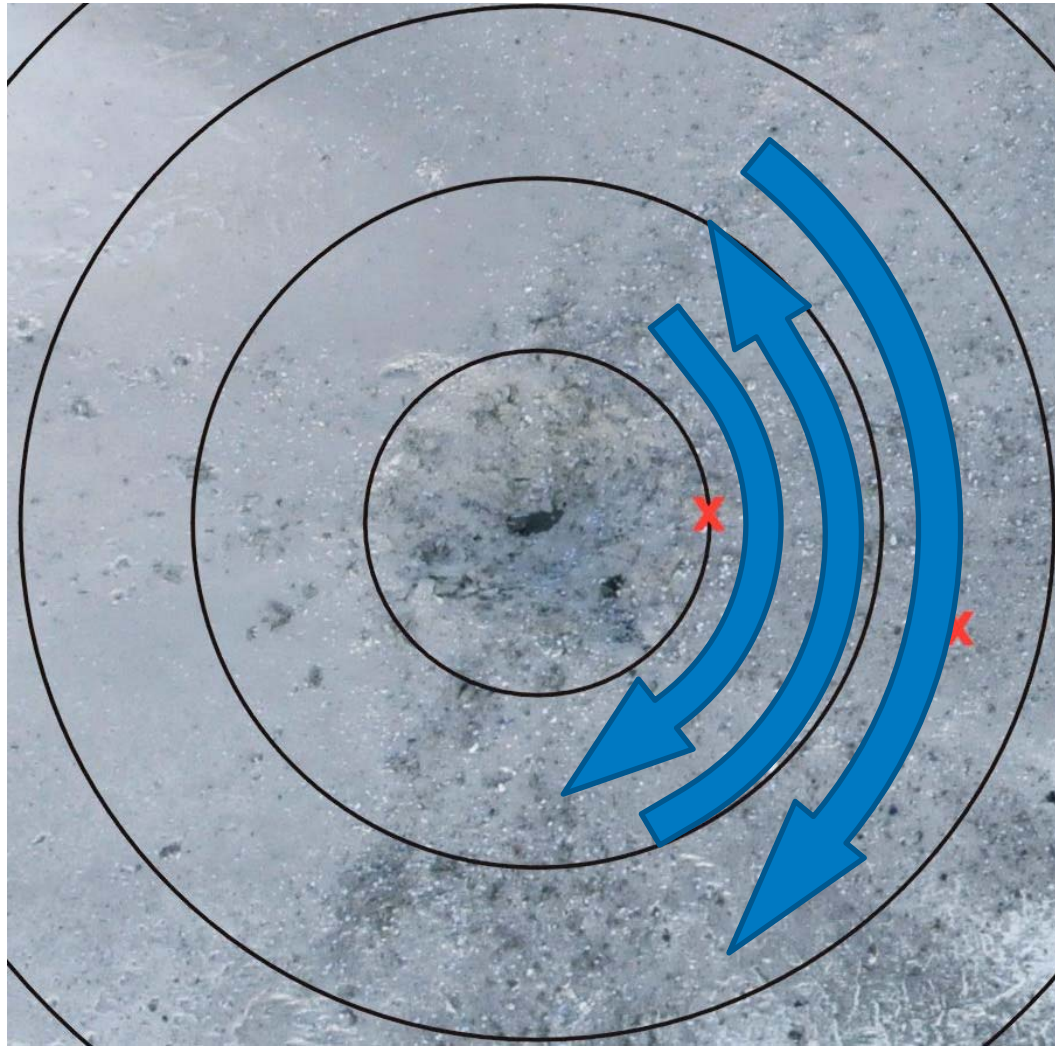
The polar method



FDR and chassis of CVR



Search pattern



Searching CVR CSMU



Search continues



Wreckage recovery



Accredited Representatives

- Canada
- France
- Norway
- Spain
- USA

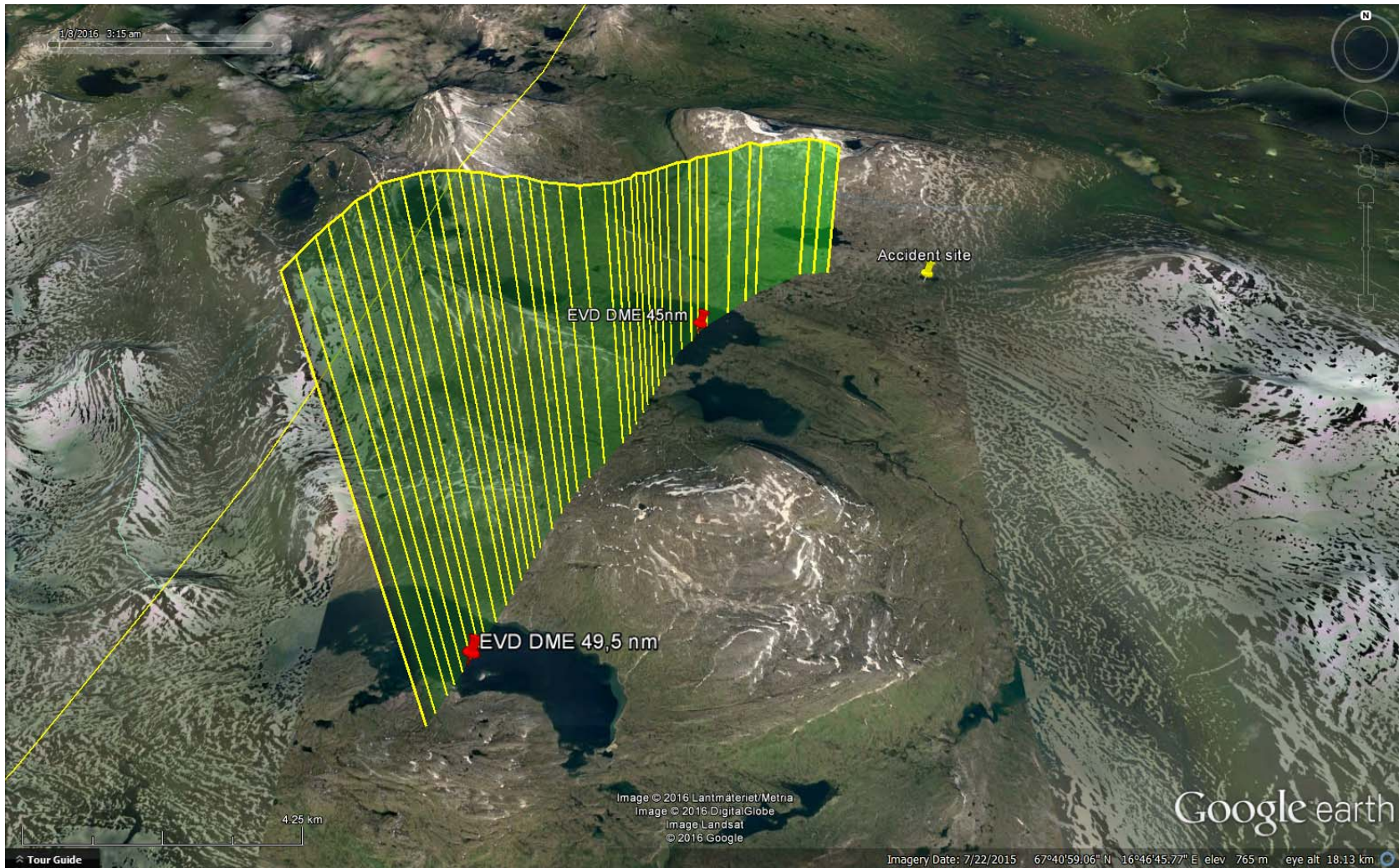
Advisors

- Swedish Transport Agency
- ICAO
- EASA
- Transport Canada
- Bombardier
- FAA
- GE
- Honeywell
- Northrop Grumman
- Rockwell Collins
- BEA

Experts

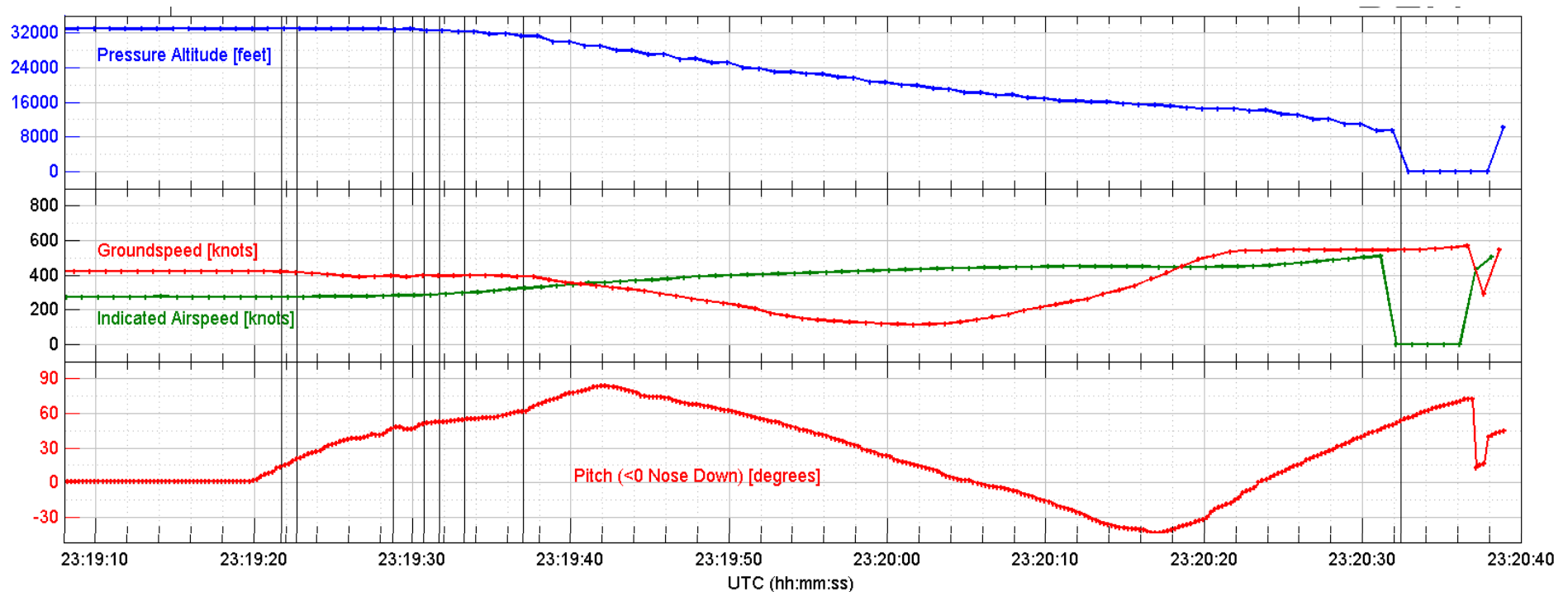
- Rescue services
- Aviation mechanics
- Aviation medicine
- Environmental physiology

Wide Area Multilateration

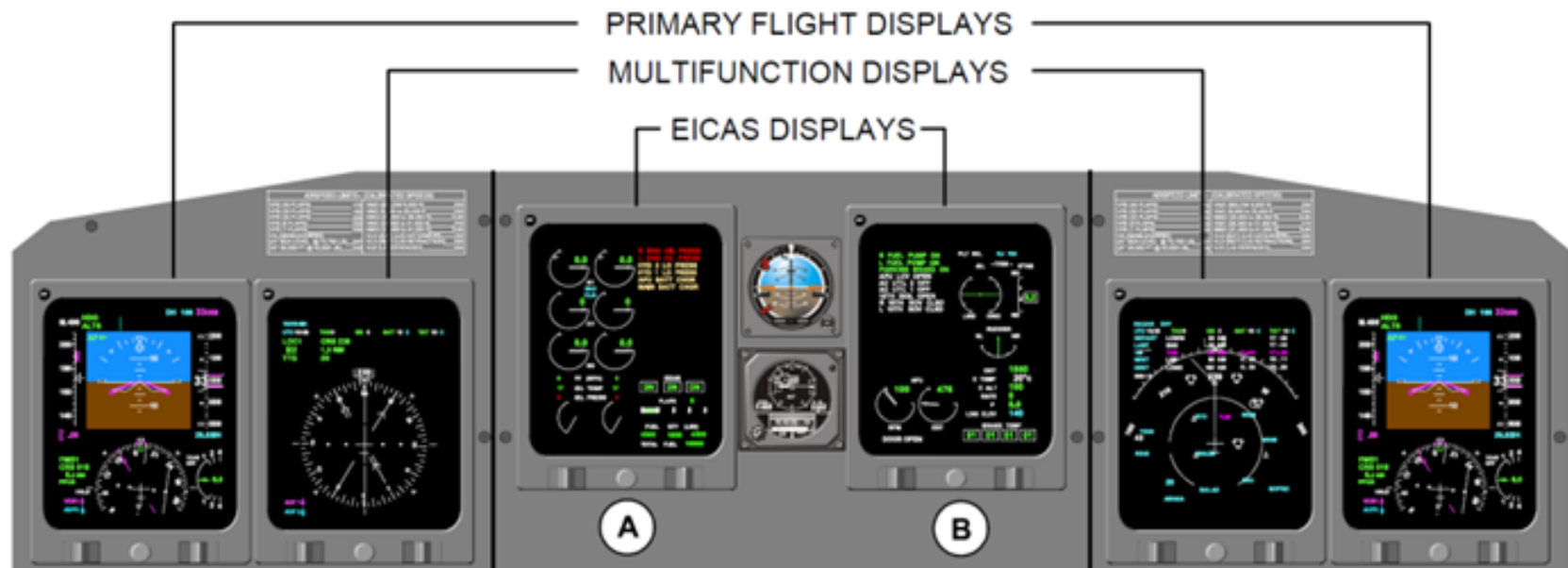


Understanding FDR-data

- pitch angle, roll angle, magnetic heading and ground speed



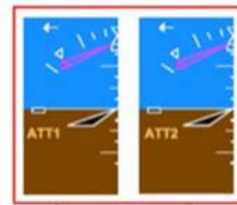
Attitude indicators



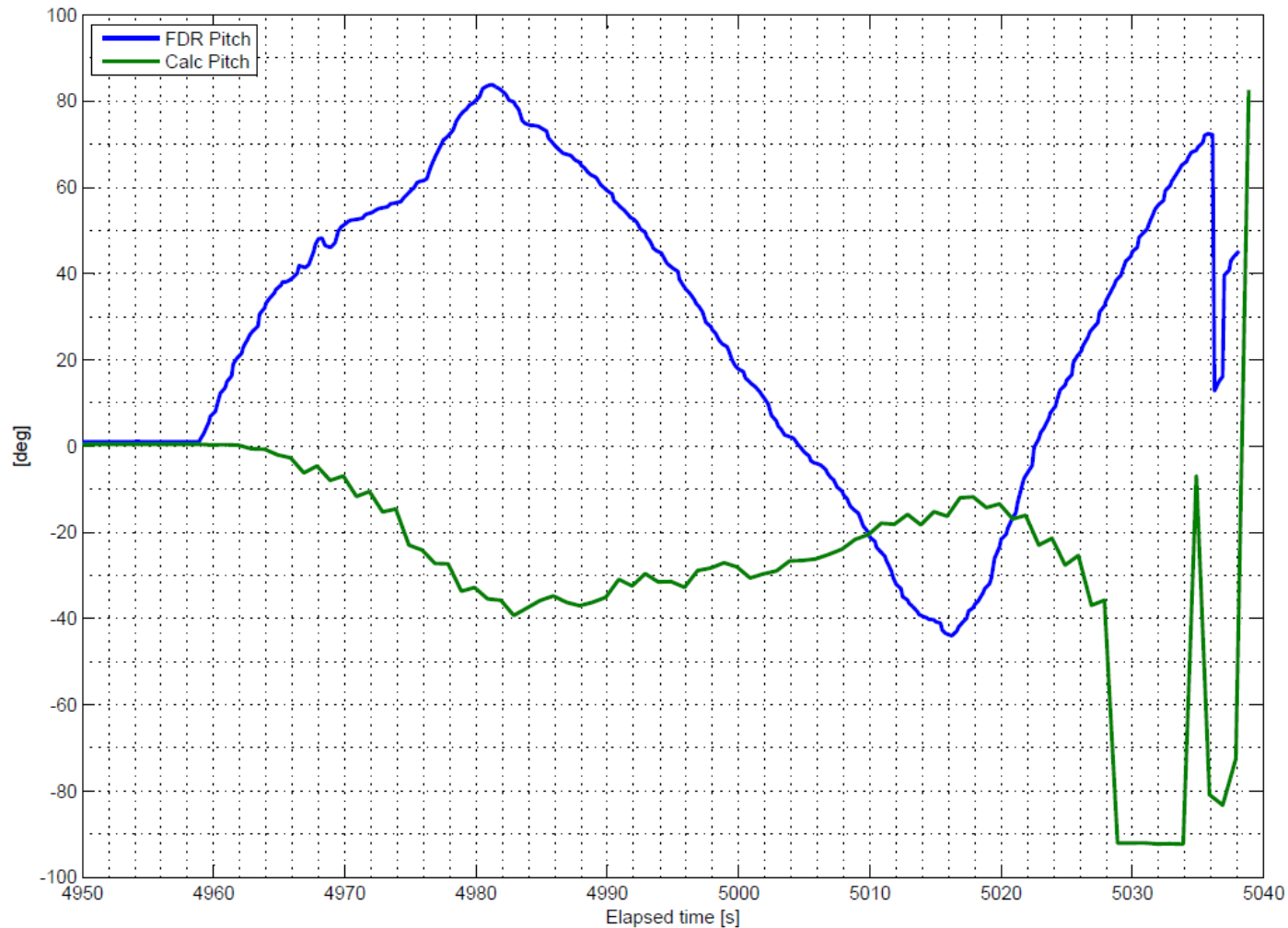
IRU 1

FDR

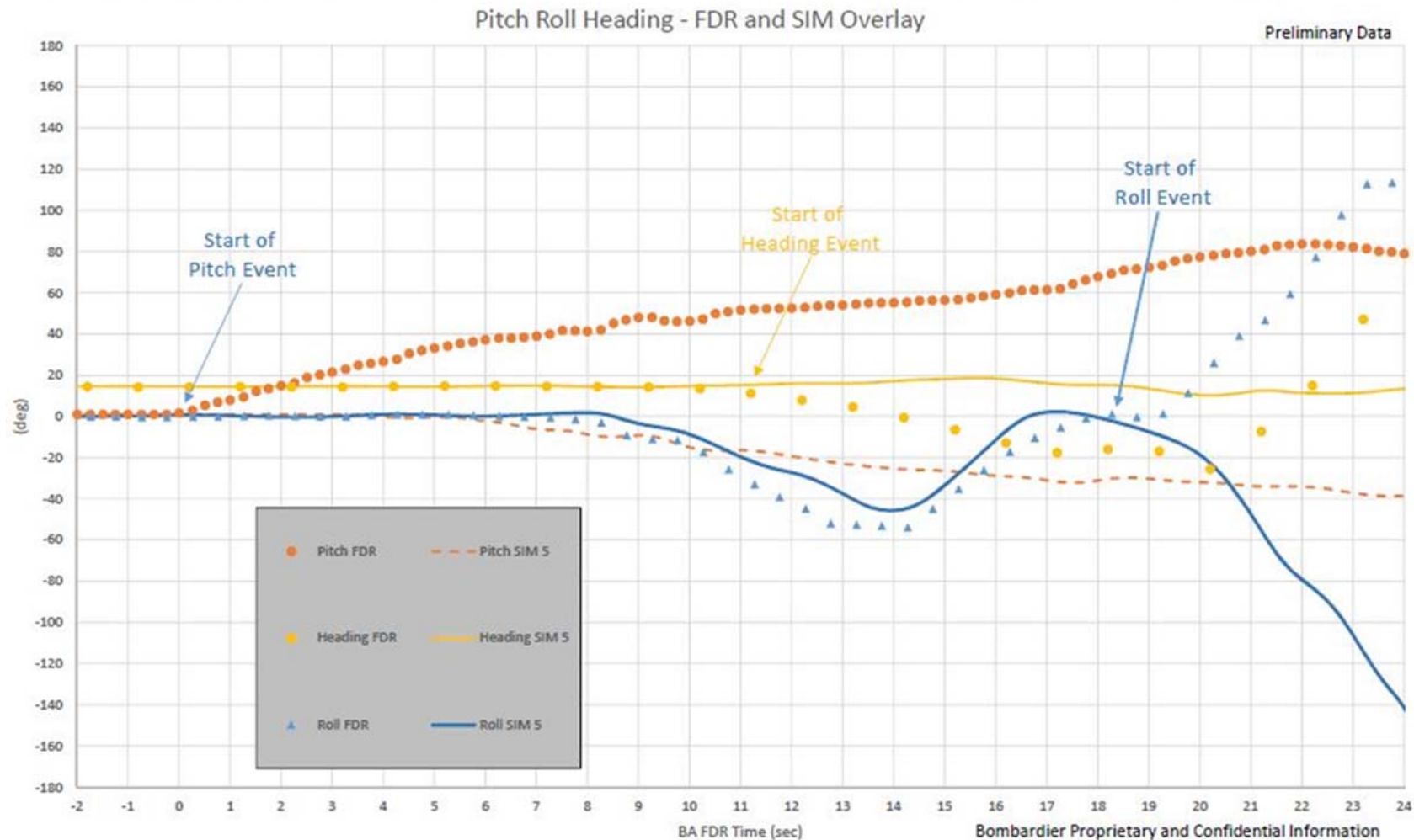
IRU 2



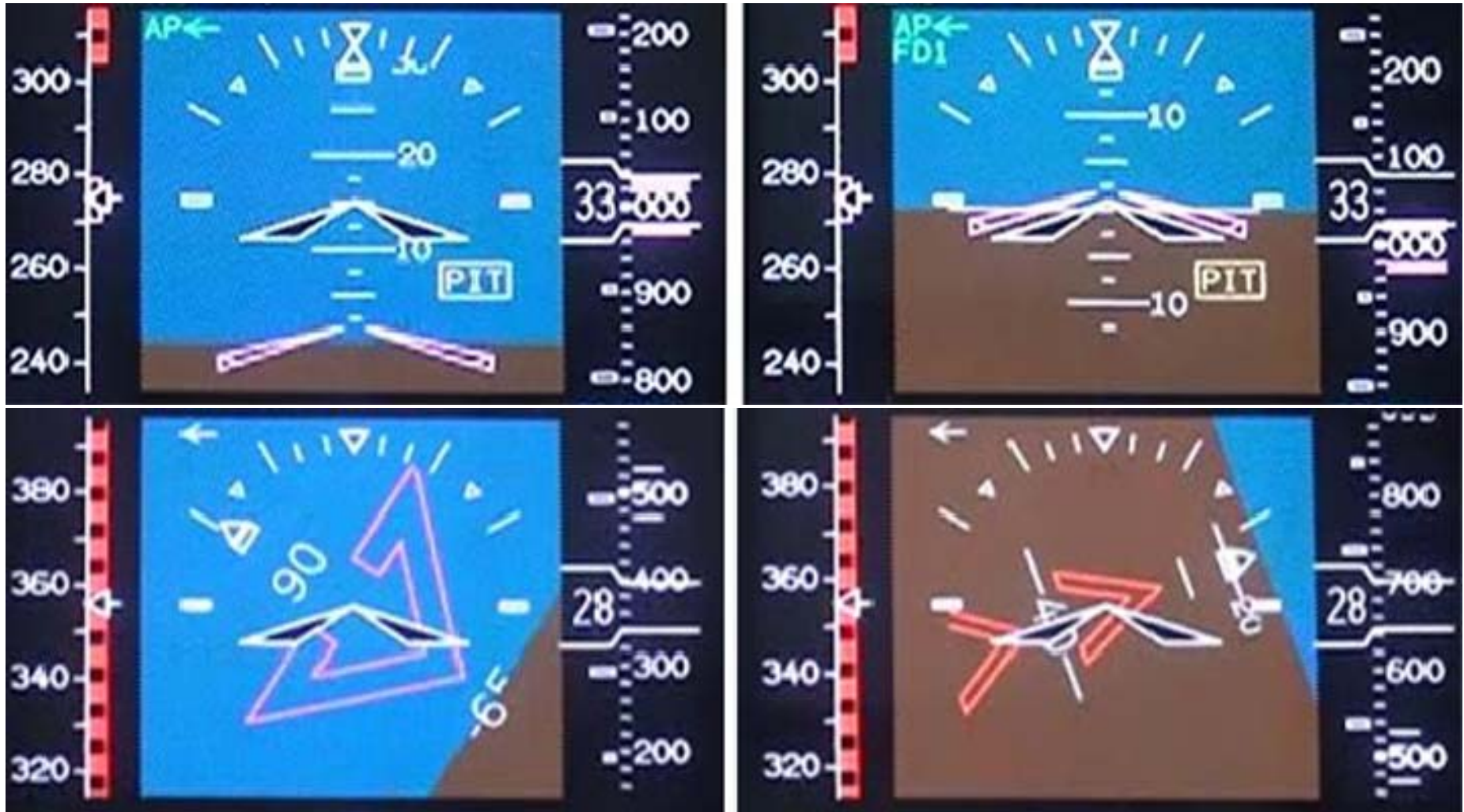
Calculation to validate pitch



FDR and simulation overlay



FDR and simulation at t2 and t22



SHK

Statens haverikommission
Swedish Accident Investigation Authority

Meetings

- Family meetings, Gällivare, Sweden
- Press conference, Luleå, Sweden
- Operator meeting, Stockholm, Sweden
- Investigation meeting, Bombardier, Montreal
- Factual information meeting with families, Stockholm, Sweden
- Factual information meeting with other stakeholders, Stockholm, Sweden (60 participants)

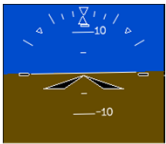
Aircraft

FL330
 IAS 275/GS 422
 HDG 014°
 Stab trim -0,9

Chimes

SV
Aural
Warning

FDR
PFD1

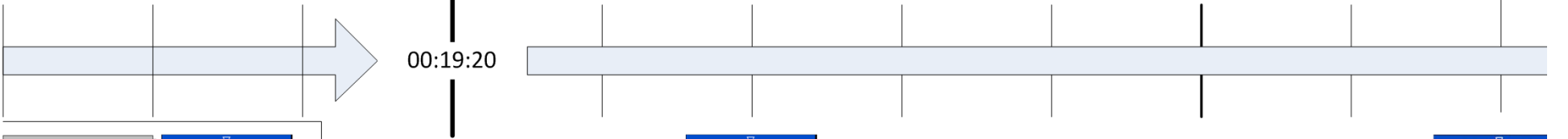


00:19:20
Pitch Change
+1,7 deg

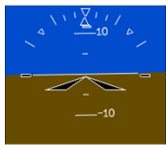



00:19:24
Pitch
+30 deg
(DECLUTTER)





PFD2


Captain

00:19:16
 "...and abeam continue descend fifteen
 hundred to turn inbound the runway "

00:19:22
"What (!)"

Crew Input

ATC

F/O

Autopilot
Disconnect
FD Down

AoA and Gz
to negative
values

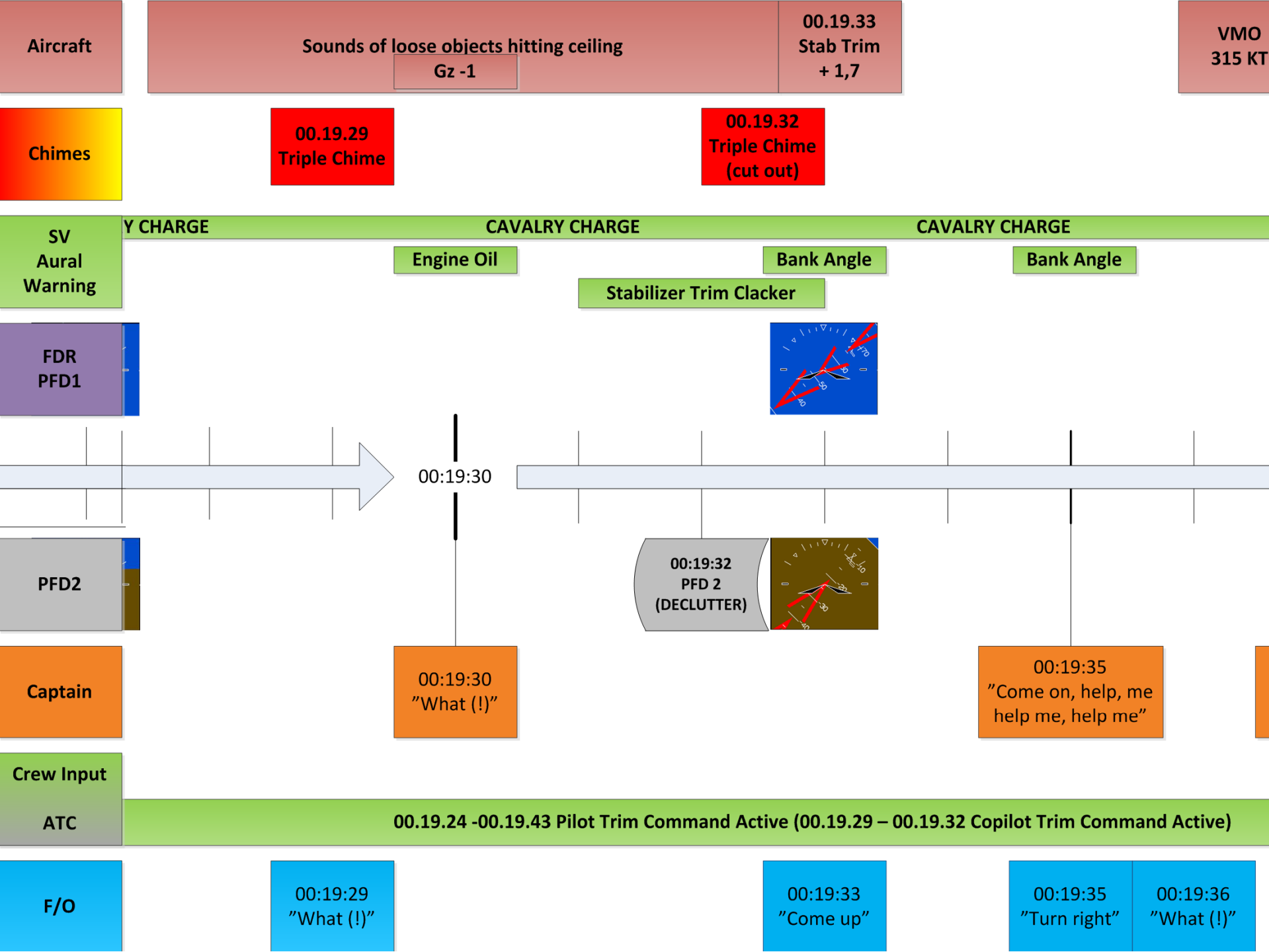
00.19.25
Descent
Trim DWN

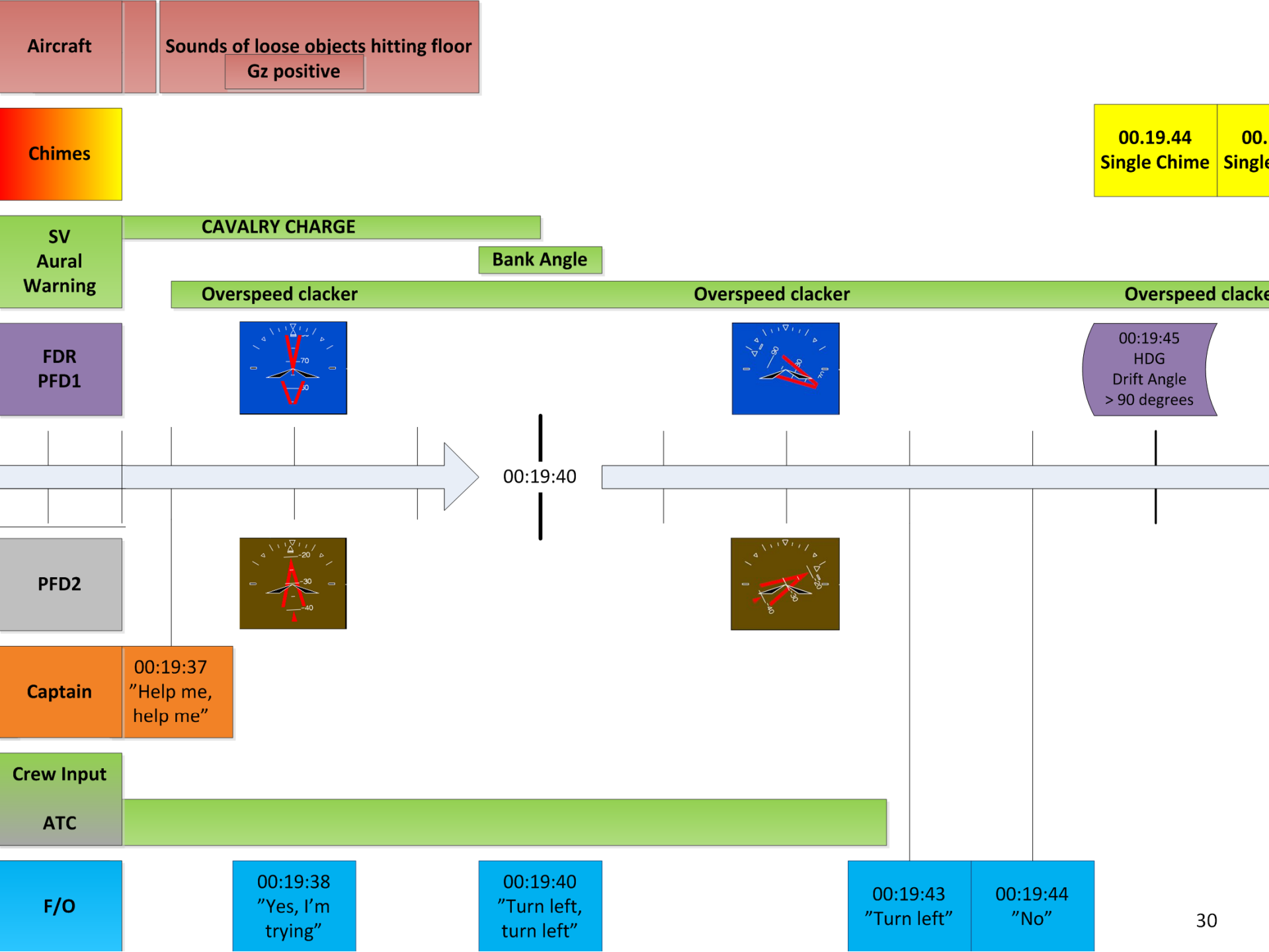
00.19.24
Single Chime
(PIT/EFIS COMP MON)

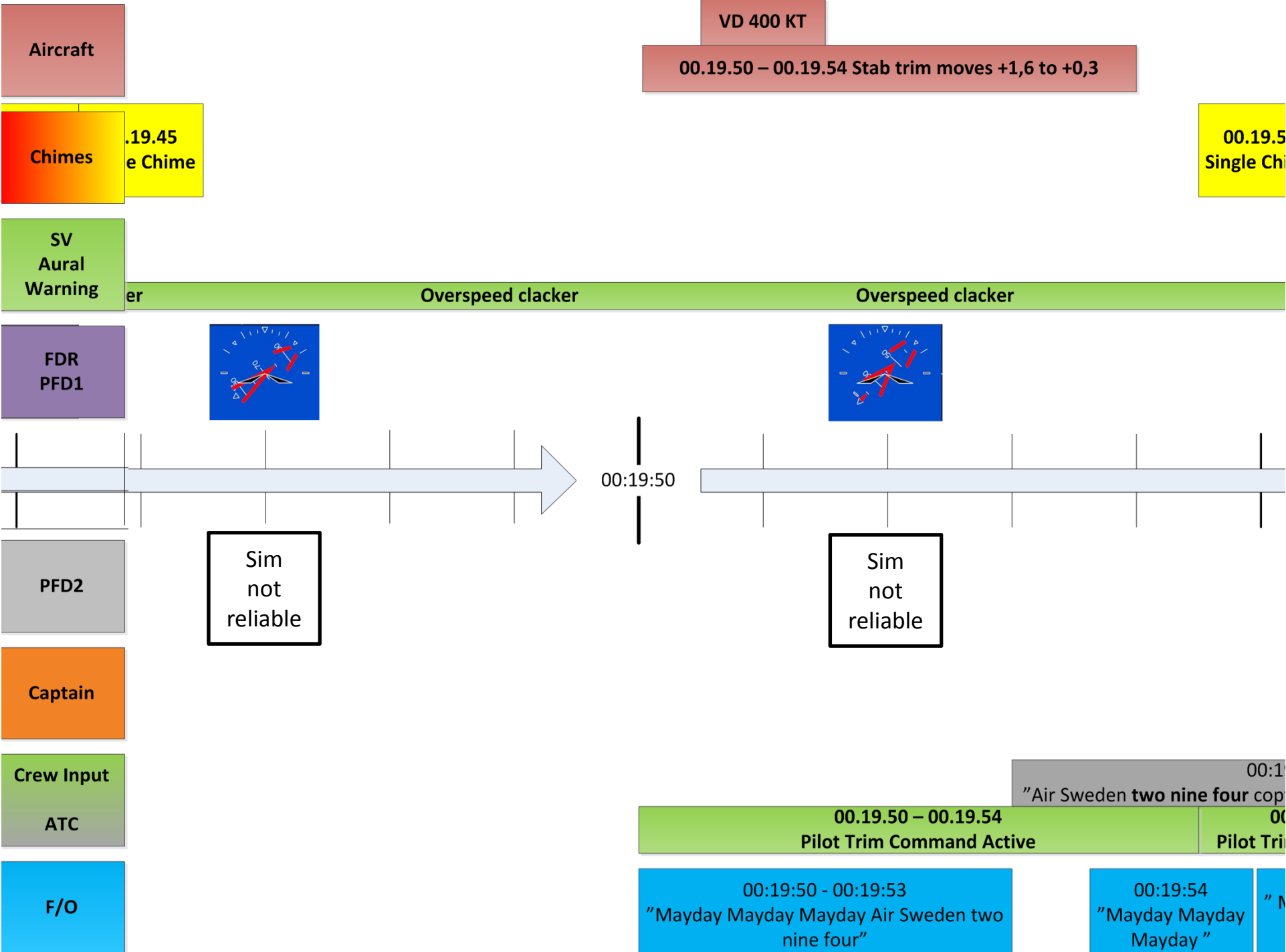
CAVALRY CHARGE

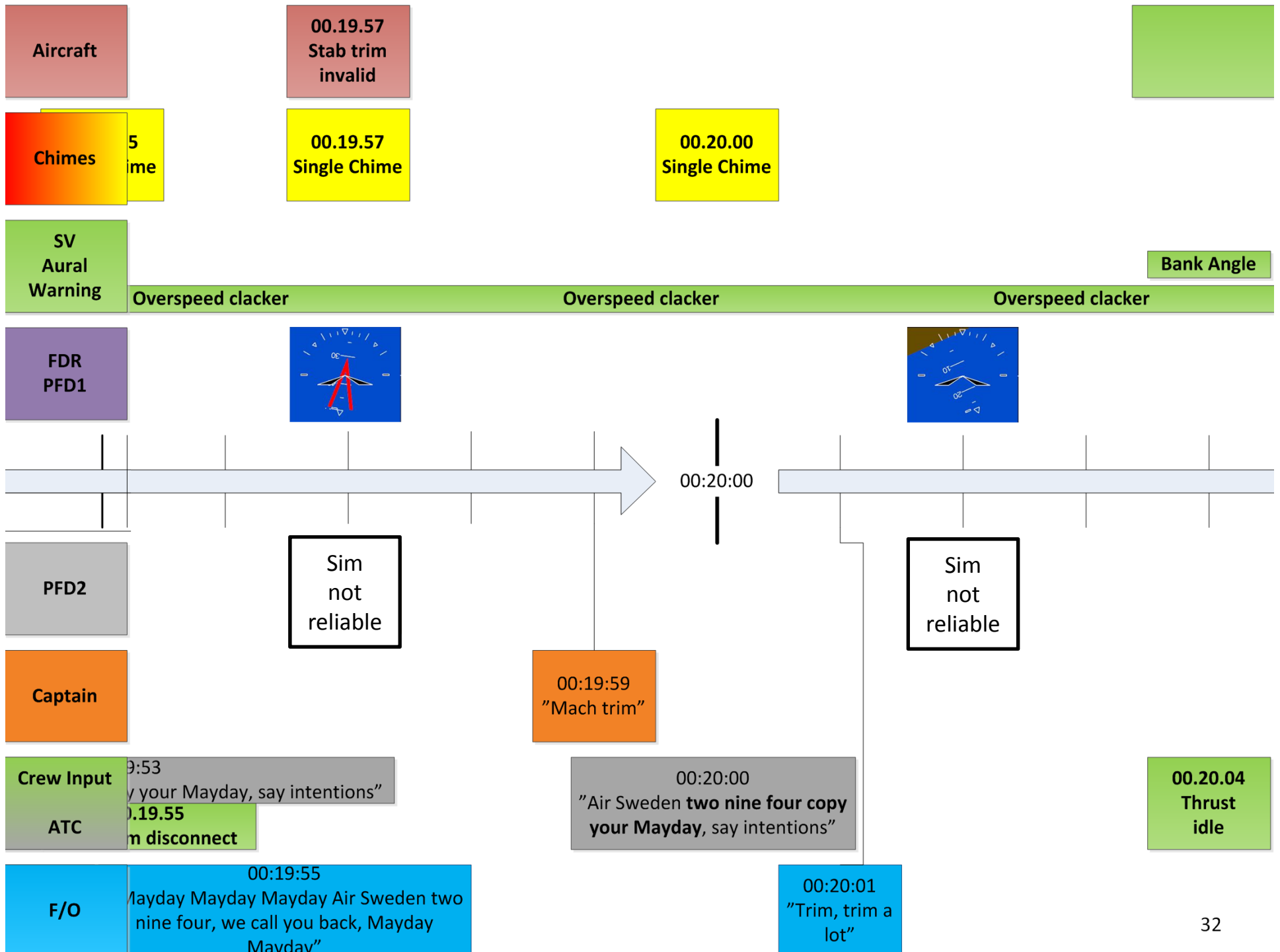
CAVALR

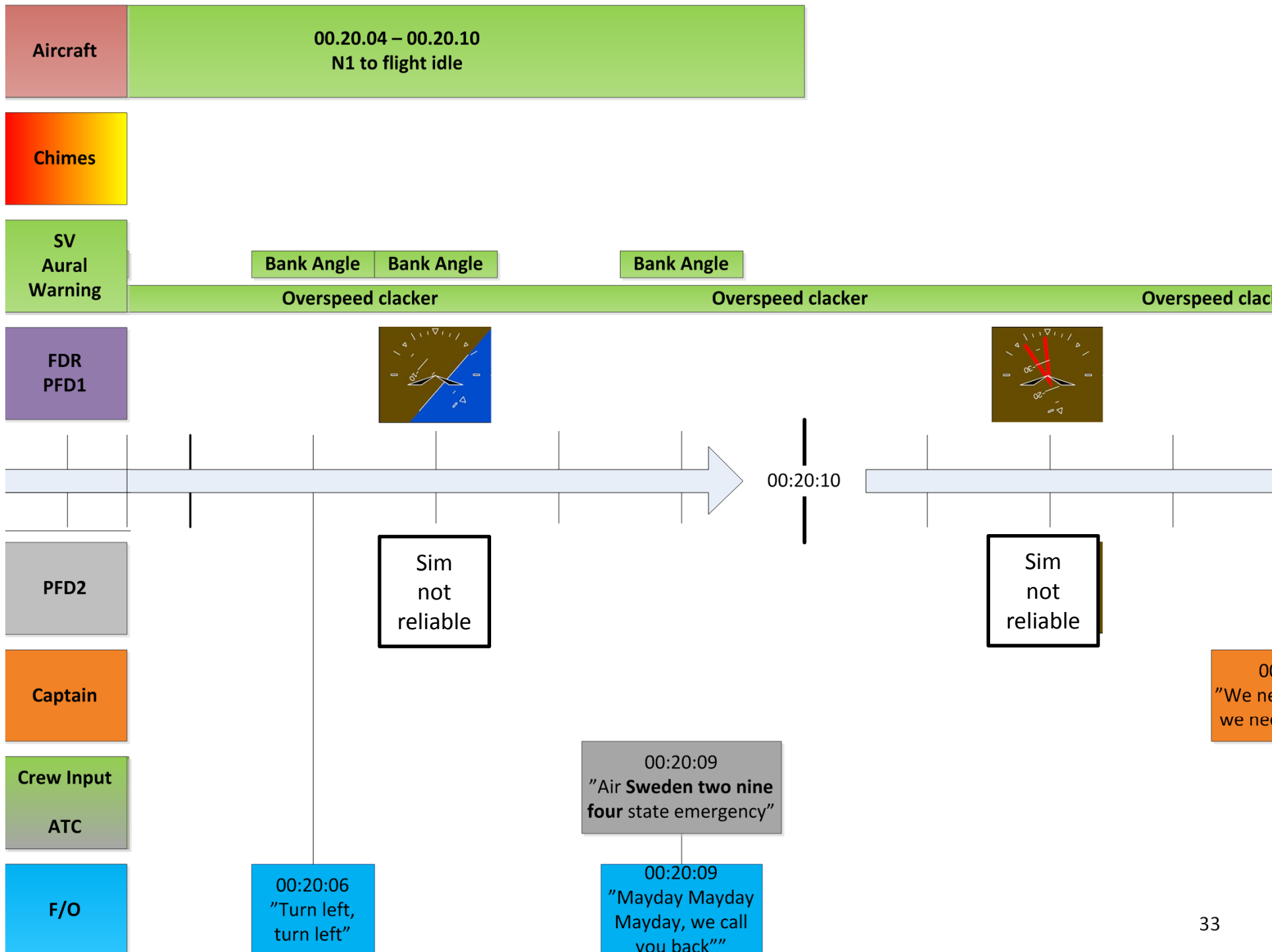
00.19.24 Elevators down

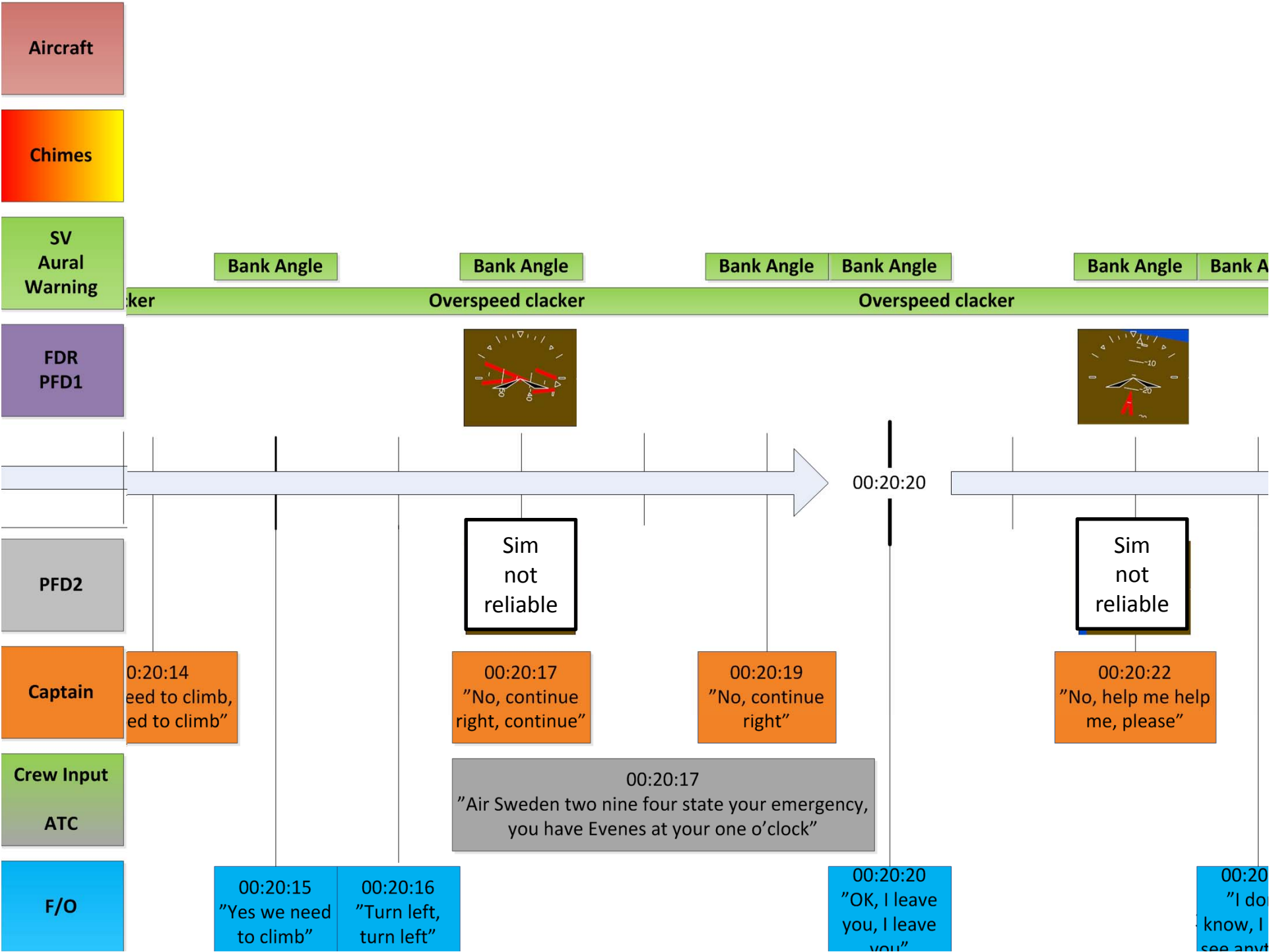


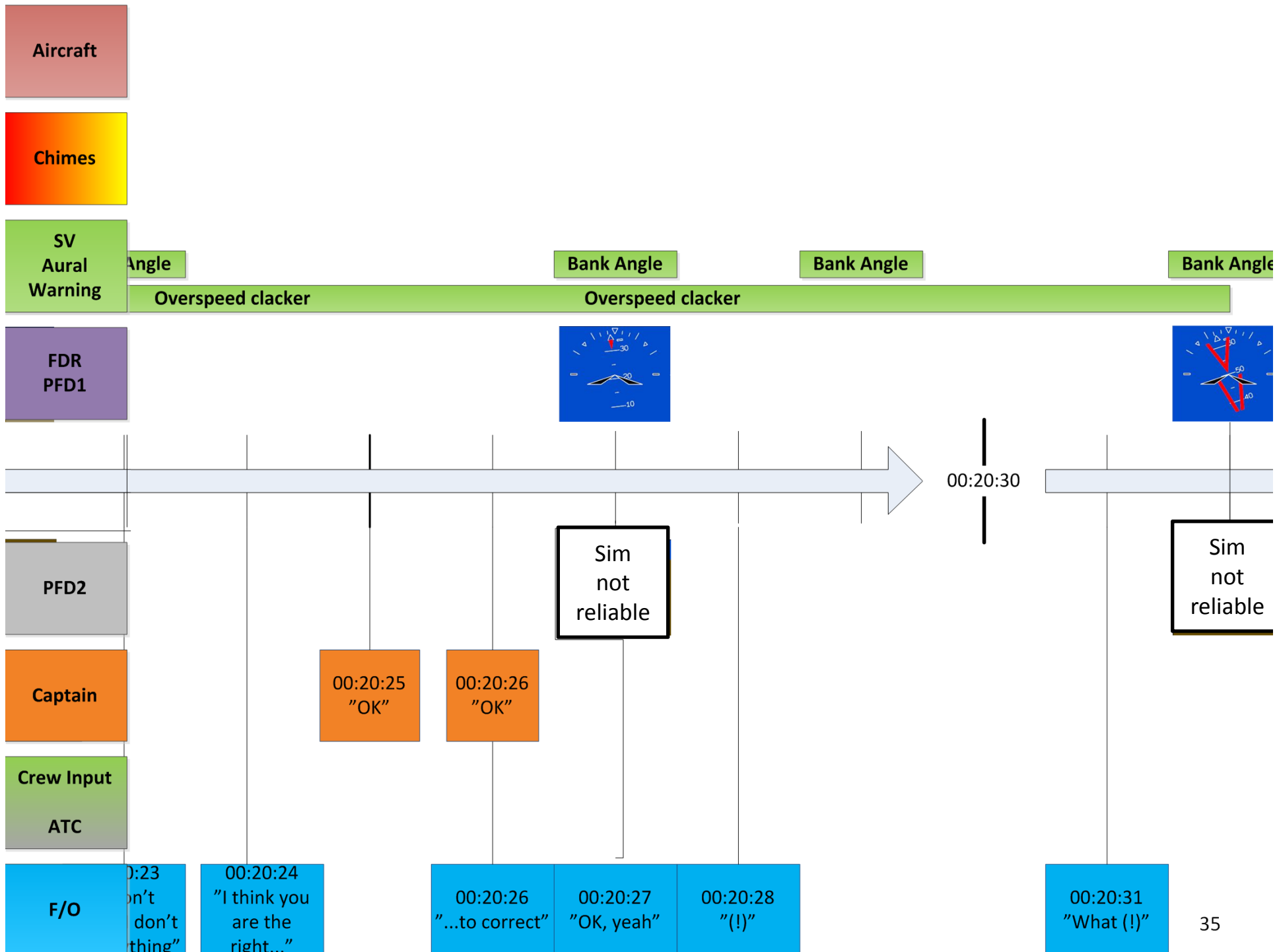


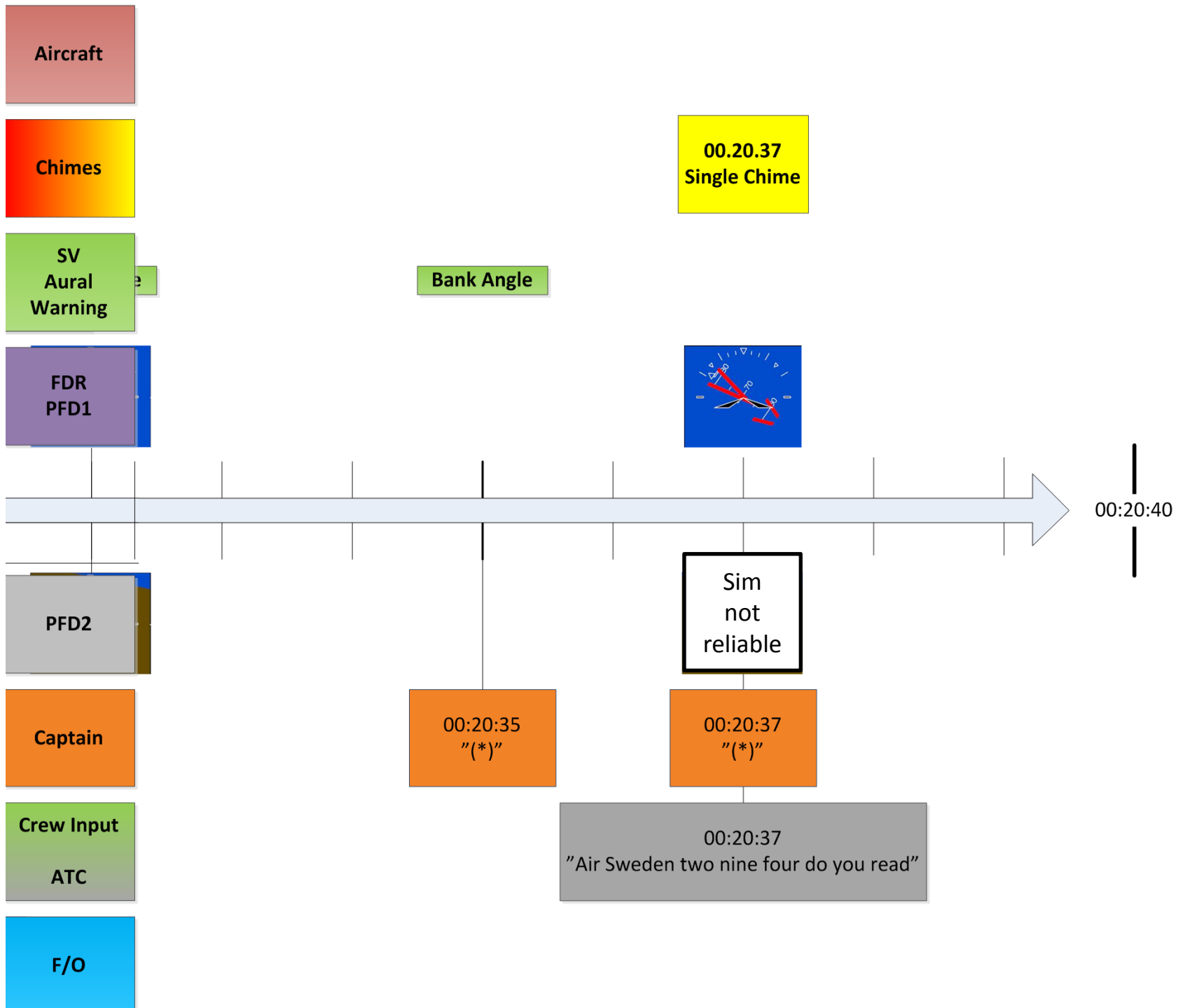












Findings

- IRU 1 produced erroneous parameters (pitch, roll and heading) without any indication of a fail message.
- The erroneous recorded parameters from IRU 1 were displayed on PFD 1.
- After autopilot disconnect, the aeroplane remained in level flight until the elevators commanded the aeroplane pitch down.
- The aeroplane was aerodynamically and structurally intact at least until VD and MD was exceeded.
- No evidence of an inflight break-up has been found.

Findings

- Information about declutter, unusual attitude and chevrons concerning the PFD units could only be found in the manufacturer's PRM.
- Information about the removal of comparator cautions in declutter mode could not be found in any manual.
- The declutter function, concerning the comparator cautions, was different between the simulator and the aeroplane.
- No callouts were found in the operator's manuals for the abnormal procedure EFIS COMP MON, neither are such callouts prescribed by regulations.
- There are no regulatory requirements for standard callouts for abnormal or unusual situations.

Factors as to cause and contributing factors

- The accident was caused by insufficient operational prerequisites for the management of a failure in a redundant system.
- Contributing factors were:
 - The absence of an effective system for communication in abnormal and emergency situations.
 - The flight instrument system provided insufficient guidance about malfunctions that occurred.
 - The initial manoeuvre that resulted in negative G-loads probably affected the pilots' ability to manage the situation in a rational manner.

Recommendations

- ICAO, EASA, Transport Canada, FAA:
 - Ensure that a general system of initial standard calls for the handling of abnormal and emergency procedures and also for unusual and unexpected situations is implemented throughout the commercial air transport industry.
- EASA, Transport Canada, FAA:
 - Ensure that the design criteria of PFD units are improved in such a way that pertinent cautions are not removed during unusual attitude or declutter modes.

The final report

- Published after 11 months
- No submissions
- Still waiting for some recommendation responses
- Report available in English at havkom.se



Questions and dialogue

