COMANDO DA AERONÁUTICA CENTRO DE INVESTIGAÇÃO E PREVENÇÃO DE ACIDENTES AERONÁUTICOS



FINAL REPORT A - 030/CENIPA/2019

OCCURRENCE: AIRCRAFT: MODEL: DATE: ACCIDENT PT-HPG 206B 11FEB2019



NOTICE

According to the Law n° 7565, dated 19 December 1986, the Aeronautical Accident Investigation and Prevention System – SIPAER – is responsible for the planning, guidance, coordination and execution of the activities of investigation and prevention of aeronautical accidents.

The elaboration of this Final Report was conducted taking into account the contributing factors and hypotheses raised. The report is, therefore, a technical document which reflects the result obtained by SIPAER regarding the circumstances that contributed or may have contributed to triggering this occurrence.

The document does not focus on quantifying the degree of contribution of the different factors, including the individual, psychosocial or organizational variables that conditioned the human performance and interacted to create a scenario favorable to the accident.

The exclusive objective of this work is to recommend the study and the adoption of provisions of preventative nature, and the decision as to whether they should be applied belongs to the President, Director, Chief or the one corresponding to the highest level in the hierarchy of the organization to which they are being forwarded.

This Report does not resort to any proof production procedure for the determination of civil or criminal liability, and is in accordance with Appendix 2, Annex 13 to the 1944 Chicago Convention, which was incorporated in the Brazilian legal system by virtue of the Decree n° 21713, dated 27 August 1946.

Thus, it is worth highlighting the importance of protecting the persons who provide information regarding an aeronautical accident. The utilization of this report for punitive purposes maculates the principle of "non-self-incrimination" derived from the "right to remain silent" sheltered by the Federal Constitution.

Consequently, the use of this report for any purpose other than that of preventing future accidents, may induce to erroneous interpretations and conclusions.

N.B.: This English version of the report has been written and published by the CENIPA with the intention of making it easier to be read by English speaking people. Taking into account the nuances of a foreign language, no matter how accurate this translation may be, readers are advised that the original Portuguese version is the work of reference.

SYNOPSIS

This is the Final Report of the 11FEB2019 accident with the 206B aircraft model, registration PT-HPG. The accident was classified as "[SCF-PP] System/Component Failure or Malfunction Powerplant – Engine Failure in Flight".

During a passenger transport flight between the Royal Palm Plaza Helipad (SSQW), Campinas - SP, to the Bandeirantes Helipad (SDBH), São Paulo - SP, the aircraft had an engine failure in flight and an unsuccessful attempt to landing was made between the Anhanguera (SP-330) and the SP-021 (Rodoanel Mário Covas) Highways.

Close to the ground, a truck-type vehicle that traveled on the Highway access lane hit the aircraft.

The truck had substantial damage to the cabin.

The aircraft was destroyed.

The truck driver left unharmed. The pilot and passenger of the helicopter died on the spot.

An Accredited Representative of the National Transportation Safety Board (NTSB) - USA, (State where the engine was designed/manufactured) and an Accredited Representative of the Transportation Safety Board (TSB) - Canada, (State where the aircraft was designed/manufactured) were designated for participation in the investigation.

CONTENTS

1. FACTUAL INFORMATION 7 1.1 History of the flight 7 1.2 Injuries to persons 7 1.3 Damage to the aircraft 7 1.4 Other damage 8 1.5 Personnel information 9 1.5.1 Crew's flight experience 9 1.5.2 Personnel training. 9 1.5.3 Category of licenses and validity of certificates. 9 1.5.4 Qualification and flight experience. 9 1.5.5 Validity of medical certificate 9 1.6 Aircraft information 9 1.7 Meteorological information 23 1.9 Communications 23 1.9 Communications 23 1.1 Flight recorders 23 1.1 Aerodrome information 25 1.13.1 Medical and pathological information 25 1.13.2 Ergonomic information 25 1.13.2 Ergonomic information 26 1.15 Survival aspects 27 1.16 Tests and research 27 1.16 Tests and research 27 1.17 Organizational and management information 42 1.19 Additional information 47 1	GLOSSARY OF TECHNICAL TERMS AND ABBREVIATIONS	5
1.2 Injuries to persons. 7 1.3 Damage to the aircraft. 7 1.3 Damage to the aircraft. 7 1.4 Other damage. 8 1.5 Personnel information. 9 1.5.1 Crew's flight experience. 9 1.5.2 Personnel training. 9 1.5.3 Category of licenses and validity of certificates. 9 1.5.4 Qualification and flight experience. 9 1.5.5 Validity of medical certificate. 9 1.6 Aircraft information. 9 1.7 Meteorological information. 23 1.8 Aids to navigation. 23 1.9 Communications. 23 1.10 Aerodrome information. 23 1.11 Flight recorders. 23 1.12 Wreckage and impact information. 23 1.13 Medical and pathological information. 25 1.13.1 Medical aspects. 25 1.13.2 Ergonomic information. 25 1.13.3 Psychological aspects. 26 1.14 Fire. 26 1.15 Survival aspects. 27 1.16 Tests and research. 27 1.17 Organizational and management information. 42 <td>1. FACTUAL INFORMATION.</td> <td>7</td>	1. FACTUAL INFORMATION.	7
1.3 Damage to the aircraft. 7 1.4 Other damage. 8 1.5 Personnel information 9 1.5.1 Crew's flight experience. 9 1.5.2 Personnel training. 9 1.5.3 Category of licenses and validity of certificates. 9 1.5.4 Qualification and flight experience. 9 1.5.5 Validity of medical certificate. 9 1.6 Aircraft information. 23 1.7 Meteorological information. 23 1.8 Aids to navigation. 23 1.0 Aerodrome information. 23 1.1 Flight recorders. 23 1.13 Medical and pathological information. 25 1.13.1 Medical aspects. 25 1.13.2 Ergonomic information. 25 1.13.3 Psychological aspects. 26 1.14 Fire. 26 1.15 Survival aspects. 27 1.16 Tests and research. 27 1.17 Organizational and management information. 42 1.18 Operational information. 45 1.19 Additional information. 47 1.20 Useful or effective investigation techniques. 48 2. ONCLUSIONS. 5	1.1 History of the flight	7
1.3 Damage to the aircraft. 7 1.4 Other damage. 8 1.5 Personnel information 9 1.5.1 Crew's flight experience. 9 1.5.2 Personnel training. 9 1.5.3 Category of licenses and validity of certificates. 9 1.5.4 Qualification and flight experience. 9 1.5.5 Validity of medical certificate. 9 1.6 Aircraft information. 23 1.7 Meteorological information. 23 1.8 Aids to navigation. 23 1.0 Aerodrome information. 23 1.1 Flight recorders. 23 1.13 Medical and pathological information. 25 1.13.1 Medical aspects. 25 1.13.2 Ergonomic information. 25 1.13.3 Psychological aspects. 26 1.14 Fire. 26 1.15 Survival aspects. 27 1.16 Tests and research. 27 1.17 Organizational and management information. 42 1.18 Operational information. 45 1.19 Additional information. 47 1.20 Useful or effective investigation techniques. 48 2. ONCLUSIONS. 5	1.2 Injuries to persons	7
1.4 Other damage 8 1.5 Personnel information 9 1.5.1 Crew's flight experience 9 1.5.2 Personnel training 9 1.5.3 Category of licenses and validity of certificates 9 1.5.4 Qualification and flight experience 9 1.5.5 Validity of medical certificate 9 1.5.5 Validity of medical certificate 9 1.6 Aircraft information 23 1.7 Meteorological information 23 1.9 Communications 23 1.0 Aerodrome information 23 1.1 Flight recorders 23 1.12 Wreckage and impact information 23 1.13 Medical and pathological information 25 1.13.1 Medical aspects 25 1.13.2 Ergonomic information 25 1.13.3 Psychological aspects 26 1.14 Fire 26 1.15 Survival aspects 27 1.16 Tests and research 27 1.17 Organizational and management information 42 1.18 Operational information 47 1.20 Useful or effective investigation techniques 48 2 ONALYSIS 48		
1.5.1 Crew's flight experience.91.5.2 Personnel training.91.5.3 Category of licenses and validity of certificates.91.5.4 Qualification and flight experience.91.5.5 Validity of medical certificate.91.6 Aircraft information.91.7 Meteorological information.231.8 Aids to navigation.231.9 Communications.231.0 Aerodrome information.231.11 Flight recorders.231.12 Wreckage and impact information.231.13 Medical and pathological information.251.13.1 Medical aspects.251.13.2 Ergonomic information.251.13.3 Psychological aspects.261.14 Fire.261.15 Survival aspects.271.16 Tests and research.271.17 Organizational and management information.471.20 Useful or effective investigation techniques.483. CONCLUSIONS.543.1 Facts.574. SAFETY RECOMMENDATION.58	1.4 Other damage	8
1.5.2 Personnel training.91.5.3 Category of licenses and validity of certificates.91.5.4 Qualification and flight experience.91.5.5 Validity of medical certificate.91.6 Aircraft information.91.7 Meteorological information.231.8 Aids to navigation.231.9 Communications.231.0 Aerodrome information.231.11 Flight recorders.231.12 Wreckage and impact information.231.13 Medical and pathological information.251.13.1 Medical aspects.251.13.2 Ergonomic information.251.13.3 Psychological aspects.261.14 Fire.261.15 Survival aspects.271.16 Tests and research.271.17 Organizational and management information.421.19 Additional information.471.20 Useful or effective investigation techniques.483. CONCLUSIONS.543.1 Facts.574. SAFETY RECOMMENDATION.58	1.5 Personnel information	9
1.5.3 Category of licenses and validity of certificates. 9 1.5.4 Qualification and flight experience. 9 1.5.5 Validity of medical certificate. 9 1.6 Aircraft information 9 1.7 Meteorological information 23 1.8 Aids to navigation 23 1.9 Communications 23 1.10 Aerodrome information 23 1.11 Flight recorders 23 1.12 Wreckage and impact information 23 1.13 Medical and pathological information 23 1.13 Medical aspects 25 1.13.1 Medical aspects 25 1.13.2 Ergonomic information 25 1.13.3 Psychological aspects 26 1.14 Fire 26 1.15 Survival aspects 27 1.16 Tests and research 27 1.17 Organizational and management information 42 1.18 Operational information 45 1.19 Additional information 45 1.14 Fore 26 1.15 Survival aspects 27 1.16 Tests and research 27 1.17 Organizational and management information 45	- ·	
1.5.4 Qualification and flight experience.91.5.5 Validity of medical certificate.91.6 Aircraft information.91.7 Meteorological information.231.8 Aids to navigation.231.9 Communications.231.0 Aerodrome information.231.11 Flight recorders.231.12 Wreckage and impact information.231.13 Medical and pathological information.251.13.1 Medical aspects.251.13.2 Ergonomic information.251.13.3 Psychological aspects.261.14 Fire.261.15 Survival aspects.271.16 Tests and research.271.17 Organizational and management information.451.19 Additional information.451.19 Additional information.451.20 Useful or effective investigation techniques.483. CONCLUSIONS.543.1 Facts.543.2 Contributing factors.574. SAFETY RECOMMENDATION.58	1.5.2 Personnel training.	9
1.5.5 Validity of medical certificate91.6 Aircraft information91.7 Meteorological information231.8 Aids to navigation231.9 Communications231.10 Aerodrome information231.11 Flight recorders231.12 Wreckage and impact information231.13 Medical and pathological information251.13.1 Medical aspects251.13.2 Ergonomic information251.13.3 Psychological aspects261.14 Fire261.15 Survival aspects271.16 Tests and research271.17 Organizational and management information421.18 Operational information451.19 Additional information471.20 Useful or effective investigation techniques482. ANALYSIS483. CONCLUSIONS543.1 Facts543.2 Contributing factors574. SAFETY RECOMMENDATION58		
1.6 Aircraft information		
1.7 Meteorological information. 23 1.8 Aids to navigation. 23 1.9 Communications. 23 1.10 Aerodrome information. 23 1.11 Flight recorders. 23 1.12 Wreckage and impact information. 23 1.13 Medical and pathological information. 23 1.13 Medical and pathological information. 25 1.13.1 Medical aspects. 25 1.13.2 Ergonomic information. 25 1.13.3 Psychological aspects. 26 1.14 Fire. 26 1.15 Survival aspects. 27 1.16 Tests and research. 27 1.17 Organizational and management information. 42 1.18 Operational information. 45 1.19 Additional information. 47 1.20 Useful or effective investigation techniques. 48 3. CONCLUSIONS. 54 3.1 Facts. 54 3.2 Contributing factors. 57 4. SAFETY RECOMMENDATION. 58	1.5.5 Validity of medical certificate	9
1.8 Aids to navigation 23 1.9 Communications 23 1.10 Aerodrome information 23 1.11 Flight recorders 23 1.12 Wreckage and impact information 23 1.13 Medical and pathological information 23 1.13 Medical aspects 25 1.13.1 Medical aspects 25 1.13.2 Ergonomic information 25 1.13.3 Psychological aspects 26 1.14 Fire 26 1.15 Survival aspects 27 1.16 Tests and research 27 1.17 Organizational and management information 42 1.19 Additional information 45 1.19 Additional information 47 1.20 Useful or effective investigation techniques 48 2. ANALYSIS 48 3. CONCLUSIONS 54 3.1 Facts 54 3.2 Contributing factors 57 4. SAFETY RECOMMENDATION 58		
1.9 Communications. 23 1.10 Aerodrome information. 23 1.11 Flight recorders. 23 1.12 Wreckage and impact information. 23 1.13 Medical and pathological information. 23 1.13 Medical aspects. 25 1.13.1 Medical aspects. 25 1.13.2 Ergonomic information. 25 1.13.3 Psychological aspects. 26 1.14 Fire. 26 1.15 Survival aspects. 27 1.16 Tests and research. 27 1.17 Organizational and management information. 42 1.18 Operational information. 45 1.19 Additional information. 47 1.20 Useful or effective investigation techniques. 48 2. ANALYSIS. 48 3. CONCLUSIONS. 54 3.1 Facts. 54 3.2 Contributing factors. 57 4. SAFETY RECOMMENDATION. 58		
1.10 Aerodrome information. 23 1.11 Flight recorders. 23 1.12 Wreckage and impact information. 23 1.13 Medical and pathological information. 25 1.13.1 Medical aspects. 25 1.13.2 Ergonomic information. 25 1.13.3 Psychological aspects. 26 1.14 Fire. 26 1.15 Survival aspects. 27 1.16 Tests and research. 27 1.17 Organizational and management information. 42 1.18 Operational information. 45 1.19 Additional information. 47 1.20 Useful or effective investigation techniques. 48 3. CONCLUSIONS . 54 3.1 Facts. 54 3.2 Contributing factors. 57 4. SAFETY RECOMMENDATION . 58		
1.11 Flight recorders. 23 1.12 Wreckage and impact information. 23 1.13 Medical and pathological information. 25 1.13.1 Medical aspects. 25 1.13.2 Ergonomic information. 25 1.13.3 Psychological aspects. 26 1.14 Fire. 26 1.15 Survival aspects. 27 1.16 Tests and research. 27 1.17 Organizational and management information. 42 1.18 Operational information. 45 1.19 Additional information. 45 1.20 Useful or effective investigation techniques. 48 3. CONCLUSIONS. 54 3.1 Facts. 54 3.2 Contributing factors. 57 4. SAFETY RECOMMENDATION. 58		
1.12 Wreckage and impact information 23 1.13 Medical and pathological information 25 1.13.1 Medical aspects 25 1.13.2 Ergonomic information 25 1.13.3 Psychological aspects 26 1.14 Fire 26 1.15 Survival aspects 27 1.16 Tests and research 27 1.17 Organizational and management information 42 1.18 Operational information 45 1.19 Additional information 45 1.20 Useful or effective investigation techniques 48 2. ANALYSIS 48 3. CONCLUSIONS 54 3.1 Facts 54 3.2 Contributing factors 57 4. SAFETY RECOMMENDATION 58		
1.13 Medical and pathological information. 25 1.13.1 Medical aspects. 25 1.13.2 Ergonomic information. 25 1.13.3 Psychological aspects. 26 1.14 Fire. 26 1.15 Survival aspects. 27 1.16 Tests and research. 27 1.17 Organizational and management information. 42 1.18 Operational information. 45 1.19 Additional information. 47 1.20 Useful or effective investigation techniques. 48 2. ANALYSIS. 48 3. CONCLUSIONS. 54 3.1 Facts. 54 3.2 Contributing factors. 57 4. SAFETY RECOMMENDATION. 58	1.11 Flight recorders2	3
1.13.1 Medical aspects. 25 1.13.2 Ergonomic information. 25 1.13.3 Psychological aspects. 26 1.14 Fire. 26 1.15 Survival aspects. 27 1.16 Tests and research. 27 1.17 Organizational and management information. 42 1.18 Operational information. 45 1.19 Additional information. 47 1.20 Useful or effective investigation techniques. 48 2. ANALYSIS. 48 3. CONCLUSIONS. 54 3.1 Facts. 54 3.2 Contributing factors. 57 4. SAFETY RECOMMENDATION. 58		
1.13.2 Ergonomic information. 25 1.13.3 Psychological aspects. 26 1.14 Fire. 26 1.15 Survival aspects. 27 1.16 Tests and research. 27 1.17 Organizational and management information. 42 1.18 Operational information. 45 1.19 Additional information. 47 1.20 Useful or effective investigation techniques. 48 2. ANALYSIS. 48 3. CONCLUSIONS. 54 3.1 Facts. 54 3.2 Contributing factors. 57 4. SAFETY RECOMMENDATION. 58		
1.13.3 Psychological aspects. 26 1.14 Fire. 26 1.15 Survival aspects. 27 1.16 Tests and research. 27 1.17 Organizational and management information. 42 1.18 Operational information. 45 1.19 Additional information. 47 1.20 Useful or effective investigation techniques. 48 2. ANALYSIS. 48 3. CONCLUSIONS. 54 3.1 Facts. 54 3.2 Contributing factors. 57 4. SAFETY RECOMMENDATION. 58	1.13.1 Medical aspects	5
1.14 Fire. 26 1.15 Survival aspects. 27 1.16 Tests and research. 27 1.17 Organizational and management information. 42 1.18 Operational information. 45 1.19 Additional information. 47 1.20 Useful or effective investigation techniques. 48 2. ANALYSIS. 48 3. CONCLUSIONS. 54 3.1 Facts. 54 3.2 Contributing factors. 57 4. SAFETY RECOMMENDATION. 58		
1.15 Survival aspects. 27 1.16 Tests and research. 27 1.17 Organizational and management information. 42 1.18 Operational information. 45 1.19 Additional information. 47 1.20 Useful or effective investigation techniques. 48 2. ANALYSIS. 48 3. CONCLUSIONS. 54 3.1 Facts. 54 3.2 Contributing factors. 57 4. SAFETY RECOMMENDATION. 58		
1.16 Tests and research.271.17 Organizational and management information.421.18 Operational information.451.19 Additional information.471.20 Useful or effective investigation techniques.482. ANALYSIS.483. CONCLUSIONS.543.1 Facts.543.2 Contributing factors.574. SAFETY RECOMMENDATION.58		
1.17 Organizational and management information.421.18 Operational information.451.19 Additional information.471.20 Useful or effective investigation techniques.482. ANALYSIS.483. CONCLUSIONS.543.1 Facts.543.2 Contributing factors.574. SAFETY RECOMMENDATION.58		
1.18 Operational information. 45 1.19 Additional information. 47 1.20 Useful or effective investigation techniques. 48 2. ANALYSIS. 48 3. CONCLUSIONS. 54 3.1 Facts. 54 3.2 Contributing factors. 57 4. SAFETY RECOMMENDATION. 58		
1.19 Additional information.471.20 Useful or effective investigation techniques.482. ANALYSIS.483. CONCLUSIONS.543.1 Facts.543.2 Contributing factors.574. SAFETY RECOMMENDATION.58		
1.20 Useful or effective investigation techniques.482. ANALYSIS.483. CONCLUSIONS.543.1 Facts.543.2 Contributing factors.574. SAFETY RECOMMENDATION.58		
2. ANALYSIS. 48 3. CONCLUSIONS. 54 3.1 Facts. 54 3.2 Contributing factors. 57 4. SAFETY RECOMMENDATION. 58		
3. CONCLUSIONS. 54 3.1 Facts. 54 3.2 Contributing factors. 57 4. SAFETY RECOMMENDATION. 58		
3.1 Facts. .54 3.2 Contributing factors. .57 4. SAFETY RECOMMENDATION. .58		
3.1 Facts. .54 3.2 Contributing factors. .57 4. SAFETY RECOMMENDATION. .58	3. CONCLUSIONS	4
4. SAFETY RECOMMENDATION		
	3.2 Contributing factors	7
5. CORRECTIVE OR PREVENTATIVE ACTION ALREADY TAKEN	4. SAFETY RECOMMENDATION	8
	5. CORRECTIVE OR PREVENTATIVE ACTION ALREADY TAKEN	9

GLOSSARY OF TECHNICAL TERMS AND ABBREVIATIONS

AMR	DCTA Material Division
ANAC	Brazil National Civil Aviation Agency
ANP	National Agency of Petroleum, Natural Gas and Biofuels
BH06	Bell 206 aircraft Type Rating
CA	Airworthiness Certificate
CBA	Aeronautics Brazilian Code
CENIPA	Aeronautical Accident Investigation and Prevention Center
CIV	Pilot's Flight Logbook
CMA	Aeronautical Medical Certificate
COA	Air Operator Certificate
COM	Maintenance Organization Certificate
CSO	Cycles Since Overhaul
CTP	Main Gearbox
DCTA	Department of Science and Airspace Technology
EDS	X-Ray Spectroscopy
EO	Operating Specifications
FAA	Federal Aviation Administration
FCU	Fuel Control Unit
FOD	Foreign Object Damage
GSO	Safety Manager
HMNT	Single Turbo Helicopter Rating
IAE	Aeronautics Space Institute
IS	Supplementary Instruction
METAR	Aviation Routine Weather Report
MEV	Scanning Electron Microscope
NM	Nautical Miles
NSCA	Aeronautics Command System Standard
NTSB	National Transportation Safety Board (USA)
OM	Maintenance Organization
PCH	Commercial Pilot License – Helicopter
PMA	Parts Manufacturer Approval
PN	Part Number
PTG	Power Turbine Governor
QAv	Aviation Kerosene
RBAC	Brazilian Civil Aviation Regulation
RNC	Non-Conformities Summary
RPM	Rotations Per Minute

A-030/CENIPA/2	2019 PT-HPG 11FEB2019
RS	Safety Recommendation
SAE	Aircraft Registration Category of Public Specialized Air Service
SBMT	ICAO Location Designator - Campo de Marte Aerodrome, São Paulo - SP
SBKP	ICAO Location Designator - Viracopos Aerodrome, Campinas - SP
SDAM	ICAO Location Designator - Campos dos Amarais State Aerodrome, Prefeito Francisco Amaral, Campinas - SP
SDBH	ICAO Location Designator – Bandeirantes Helipad, São Paulo - SP
SSQW	ICAO Location Designator – Royal Palm Plaza Helipad, Campinas - SP
SIPAER	Aeronautical Accident Investigation and Prevention System
SN	Serial Number
ТВО	Time Between Overhaul
тс	Computed Tomography
TPX	Aircraft Registration Category of Non-Regular Public Air Transport
TSO	Time Since Overhaul
UTC	Universal Time Coordinated
VTE	Special Technical Inspection
W/O	Work Order
XRF	X-Ray Fluorescence

1. FACTUAL INFORMATION.

	Model:	206B	Operator:
Aircraft	Registration:	PT-HPG	RQ Serviços Aéreos Especializados
	Manufacturer:	Bell Helicopter	Ltd.
	Date/time:	11FEB2019 - 1405 UTC	Type(s):
Occurrence	Location: Inter and SP-021 Hig	section between SP-330 Jhways	[SCF-PP] System/Component Failure or Malfunction Powerplant
	Lat. 23°27'08"S	Long. 046°47'12"W	Subtype(s):
	Municipality –	State: São Paulo – SP	Engine Failure in Flight

1.1 History of the flight.

The aircraft took off from the Royal Palm Plaza Helipad (SSQW), Campinas - SP, to the Bandeirantes Helipad (SDBH), São Paulo - SP, at about 1345 (UTC), in order to transport personnel, with a pilot and a passenger on board.

With about twenty minutes of flight, the aircraft made an emergency landing attempt at an intersection between the Anhanguera Highway and Rodoanel Mário Covas.

Security cameras from the concessionaire that managed the highway, captured images indicating that the aircraft performed a self-rotation, possibly aiming to land on the grassy area between the two upper lanes of the Rodoanel.

As the maneuver was unsuccessful, the aircraft passed between the two viaducts and was hit, still in flight, by a truck traveling on the access road to the Highway.

The truck had substantial damage to the cabin and the driver left unharmed.

The aircraft was destroyed.

The helicopter crewmember and the passenger died on the spot.

1.2 Injuries to persons.

Injuries	Crew	Passengers	Others
Fatal	1	1	
Serious		-	
Minor	-	-	-
None		-	-

1.3 Damage to the aircraft.

The main Gearbox (CTP), the blades, the engine and the fuselage were severely damaged by the impact and the action of fire (Figure 1).



Figure 1 - Wreckage of the main Gearbox (CTP), the blades, the engine and the fuselage.

The tail boom was sectioned due to the impact and did not suffer the action of fire (Figure 2).



Figure 2 - Sectioned tail boom.

1.4 Other damage.

A truck-type vehicle had substantial damage to the cabin, specifically in the upper front portion, front grille and windshield (Figure 3).

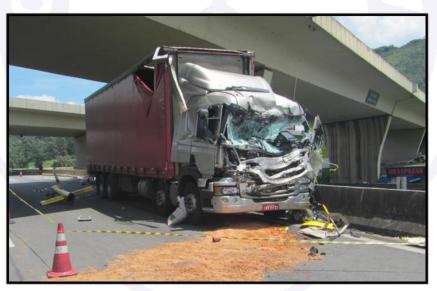


Figure 3 - View of the damaged vehicle after the collision with the aircraft.

1.5 Personnel information.

1.5.1 Crew's flight experience.

Flight Hours	Pilot
Total	Unknown
Total in the last 30 days	Unknown
Total in the last 24 hours	Unknown
In this type of aircraft	Unknown
In this type in the last 30 days	Unknown
In this type in the last 24 hours	Unknown

N.B.: The Pilot's Flight Logbook was not found. The partial data, related to the flown hours, were obtained through the records contained in the ANAC's CIV - Digital system.

The last information launched at the CIV - Digital system was dated 12JUN2018.

It was also found that the information contained in the CIV - Digital system did not correspond to the movements of the aircraft registered at the Campo de Marte Aerodrome (SBMT), São Paulo - SP, where the aircraft was based. According to the information collected, the pilot had more total flight hours than those mentioned in the system, including in that aircraft model.

1.5.2 Personnel training.

The pilot took the PPH course at the São Paulo Aeroclub, in 1999.

1.5.3 Category of licenses and validity of certificates.

The pilot had the PCH License and had valid HMNT Rating.

1.5.4 Qualification and flight experience.

The pilot was performing a non-scheduled public air transport flight in the air taxi mode, which could only be performed by an operator subject to operational certification under the terms of the RBAC 135.

In order to operate in accordance with this RBAC, it would be necessary that, in addition to the Air Operator Certificate (COA), issued on behalf of the certificate holder, and the authorization to provide remunerated public air transport services for passengers or cargo, the operator had submitted a training program approved by the ANAC that would ensure adequate training for the performance of each crewmember's duties.

The RQ Serviços Aéreos Especializados Ltd. did not have an approved operational training program and was not certified by the ANAC, according to RBAC 135, and did not have authorization to provide remunerated public air transport services for passengers or cargo.

That considered, it was concluded that the pilot was not qualified in the type of flight (air taxi), being unable to get his experience in the type of operation that was being performed.

1.5.5 Validity of medical certificate.

The pilot had valid CMA.

1.6 Aircraft information.

The aircraft, 206B model, serial number 1705, was manufactured by Bell Helicopter, in 1975 and was registered in the SAE Category.

The Airworthiness Certificate (CA) was valid.

PT-HPG 11FEB2019

A-030/CENIPA/2019

The aircraft had flown 8 hours and 20 minutes after the last inspections carried out by the Maintenance Organization (OM) WM Helicopters, Maintenance Organization Certificate (COM) n^o 0304-05/ANAC), on 06DEC2018.

The inspections were of the following types:

- "400 hours/12 months" of the battery;
- "100 hours/12 months" of the battery installation kit;
- "24 months" of the aircraft;
- "100 hours/90 days" for aircraft corrosion control;
- "weekly" of the aircraft;
- "1.200 hours/24 months" of the aircraft components;
- "transponder recertification";
- "balancing of the main rotor"; and
- "flight test".

It was equipped with an M250 engine, which in terms of maintenance, was originally developed to allow modular overhaul. The major components of the engine were the compressor, the Gearbox and the turbine (Figure 4).

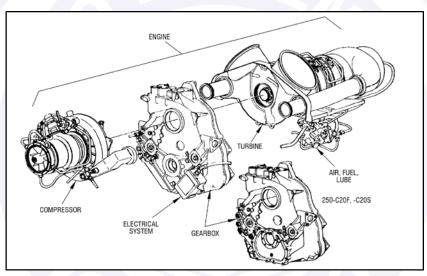


Figure 4 - Overview of the modules.

A premature removal of any of these components did not cause the removal of the others, unless a secondary damage had occurred.

For operators using Modular Overhaul, the Rolls-Royce recommended an interval between overhauls - Time Between Overhaul (TBO) as listed in Figure 5 below:

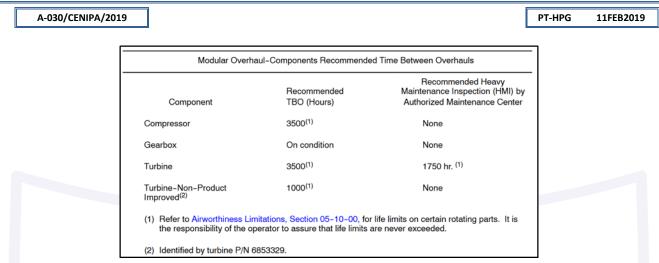


Figure 5 - Recommended Time Between General Overhauls in the M250-C20 Series Overhaul Manual.

There was the possibility that the permitted operating life limit of certain parts specified in the Airworthiness Limitations, Section 05-10-00 (Maintenance and Operation Manual), was exceeded before the recommended TBO. Therefore, it was the operator's responsibility to ensure that neither the total time nor the operating life limit of any of these components were exceeded.

The M250-C20 Series Overhaul Manual described, among other things, that one of these components, bearing nº 2, which was the back support part of the compressor rotor, should be inspected and subjected to acceptance criteria during the overhaul of the compressor module.

During the investigation, despite requests made to the operator, it was not possible to locate and access the entire maintenance records of the PT-HPG aircraft.

The Investigation Team had access to the following maintenance records and service reports performed:

- Helicopter Airframe Logbook nº 05, branded PT-HPG, with opening term dated 01DEC2012, handed out by the Maintenance Organization WM *Helicópteros*.

- The Rolls Royce Engine Logbook, model 250-C20, Serial Number (SN) CAE-821758. It was not possible to specify the logbook number, due to the erasure in the identification of the number in the opening term. It was also observed that some pages were identified with the number 02, others with the number 03 and some without identification. The OM WM Helicópteros handed out the material.

- Service Order nº 3408 dated 18OCT2017, issued by the OM WM *Helicópteros*, with 18 copies of maintenance records.

- Service Order nº 3469 dated 16MAY2018 and its annexes, issued by the OM WM Helicópteros.

- Service Order nº 3540 and its annexes, dated 06DEC2018, issued by the OM WM *Helicópteros*.

- Components Control and Airframe Inspections of the helicopter branded PT-HPG, issued by the OM WM *Helicópteros*, dated 06DEC2018.

- Components Control and Rolls Royce Engine Inspections, model 250-C20, SN CAE-821758, issued by the OM WM *Helicópteros*, dated 06DEC2018.

- Airframe Airworthiness Guidelines Controls for the PT-HPG helicopter and the Rolls Royce engine, model 250-C20, SN CAE-821758 issued by the OM WM *Helicopteros*.

- Copy of Airframe Logbook nº 02 of the Rolls Royce engine, model 250-C20, SN CAE-821758, with opening term dated 15MAR2003, handed out by the OM HBR *Aviação SA*.

- Copy of Airframe Logbook nº 02 of the helicopter branded PT-HPG, with opening term dated 15MAR2003, handed out by the OM HBR *Aviação SA*.

- Copy of Airframe Logbook nº 05 of the helicopter branded PT-HPG, with opening term dated 01DEC2012, handed out by the OM HBR *Aviação SA*.

- Copy of Service Order nº 0677/2017 and its annexes, dated 20JUL2017, issued and handed out by the OM HBR Aviação SA.

- Copy of Service Order nº 0481/2015 and its annexes, dated 20JUL2017, issued and handed out by the HBR *Aviação SA* Maintenance Organization.

- Copy of Service Order nº 0778/2016 and its annexes, dated 20JUL2017, issued and handed out by the OM HBR Aviação SA.

- Copy of part of the item history sheets (Log Cards) of the PT-HPG aircraft airframe handed out by the OM HBR *Aviação SA*.

 Copy of part of the Log Cards of the Rolls Royce engine, model 250-C20, SN CAE-821758 handed out by the OM HBR Aviação SA.

- Copy of the monthly report of services performed by the Aeronaves Turbinas e Componentes Ltd. Company (ATC) referring to December 2011.

- Copy of the SEGVOO 003 $n^{\rm o}$ ATC 00414/2011 and the SEGVOO 003 $n^{\rm o}$ ATC 00417/2011.

The analyzed airframe and engine logbooks did not have updated records (Part I). The last registration in both logbooks had been made in December 2018 (Figure 6).

CADE	RNETA	DE CÉ	LULA Nº	051	PTHPC		112			Nº S	SÉRIE_	1 tes
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07/17	8.1	19	158664	837!	959149	6	1				2.0	
61180	52	10	158716	8381	759139	P	1					
9118	82	17	15827.8	8398	959259	FD	1					
1010	11	3	15 8809	8401.	957739	R	1					
11/18	3.6	9	158845	R410.	159439	P	1					
81 E1	52	16	158897	8428	25929	10	1					
0119							1					
014/15	51											
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9/10	TRANSPO	DRTE ->	8398.	NA.	959239	M	1	TRANSPOR	RTE ->-			
10/18	11	3	134432	MA.	959239	P	1					200
11/8	3.6	9	8410	ZA.	957239	D	1	and -	22			229
118	52	18	3452.0 Ruda	MA.	95977	Þ	1	0.0				11
119	40	12			1010		1	200	NS-			11
- 1 C	1.000					-				1.1.1	1.14	

Figure 6 - Last monthly usage record in Part I of airframe logbook number 05/PT-HPG/12 and engine logbook number 03.

In accordance with item 5.6.2 of Supplementary Instruction (IS) nº 43.9-003, Revision A, of ANAC, the updating of Part I of the airframe and engine logbooks should have been done by the fifth day of the subsequent month and, in case of an aircraft, engine or propeller operates after an inactive period longer than one month, this inactivity should be mentioned in a single line in the Monthly Control of Parts I field of the respective logbooks.

Airframe Logbook 02/PT-HPG/03 had its opening term registered on 15MAR2003 and closing on 01DEC2012 (Figures 7 and 8). Afterwards, it was found that the opening term of Airframe Logbook 05/PT-HPG/12 was dated 01DEC2012 (Figure 9), the same day of the closing of logbook 02/PT-HPG/03 (Figure 8).

Airframe logbooks numbers 03 and 04 of the PT-HPG aircraft were not found and/or presented.

Aos 15 dias do mês de 7 "Termo de Abertura" desta Ca numeradas, que servirá para inspeção, revisão, reparo, ins	IODE ABERTURA do ano de <u>2003</u> , lavra-se o presente demeta de Célula, contendo 151 páginas devidamente a escrituração de todos os serviços de manutenção, stalação e remoção de componentes, incorporação de ade, de modificações e de reparos na aeronave abaixo
	: 3ELL Modelo: 2063 N/S: 1705
TSN: 14166.2 C	CSN: N/A Ano de Fabricação: 1975
Proprietário: PHILOMENA ALIEUSTO Observações:	DSUVA Operador: GABRICE REPOTAXI KDP
<mark>S. Philo, 15 <i>De MARÇO, De 200</i> 3</mark> Local e Data	3 Nome e As <mark>sinatura do Responsável pelo Termo de Abertura</mark>
gure 7 – Opening Tern	n for Airframe logbook nº 02 / PT-HPG / (
	151
	CÉLULA Nº OU INT-HR I OS

presente "Termo de Encerramento" desta Caderneta de Célula, que serviu para a escrituração de todos os registros de manutenção, inspeção, modificações, reparos, instalação e remoção de componentes da aeronave abaixo identificada:

	ZC Modelo: 26 B N/S: 170.5 21.4 Ano de Fabricação: 7.5 Operador: PQ F15
Spark of 12/212	ROSERVIÇOS AEREUS SNPJ: 96 175 807/0001-78

Figure 8 - Closing Term for Airframe logbook nº 02 / PT-HPG / 03.

A-030	/CENIPA/2019
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	TERMO DE ABERTURA
Termo de A umeradas, ospeção, re iretrizes de lentificada	
arcas: Pt. 1	1PG_Fabricante: Bull 121-Copter Modelo: 206B_N/S: 1705_
SN: 15.3	587.2 CSN:Ano de Fabricação: 1975_
oprietário:	29. Services Años Operador: RG Services Anes Specilies
bservações:_	
	R.Q. Serviço Aéreo Especializado

PT-HPG

11FEB2019

Figure 9 - Opening Term for Airframe logbook nº 05 / PT-HPG / 12

In addition, there were signs of erasures on the inside pages of both logbooks and pages without identification and/or with their identification in disagreement with the opening term, according to Figures 10, 11, 12, 13, 14 and 15.

DATA DWEAA	TSN CBN	S PRIMARU S DE MANUTE NÇÃO, INSPEÇÃ	CENTRICO A	ADIFICAÇÕES E PEQUENOS REPAI EXECUÇÃO E A AEROARVEGABLIDADE (des 41.5 + 41.11 do 1804A 43)
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		A DE CÉLULA Nº 021	and the second s	
RTE		STROS PRIMÁRIOS DE MANO	and the second s	1 <u>03</u> D, REVISÃO, PEQUENAS
		and the second s	and the second s	

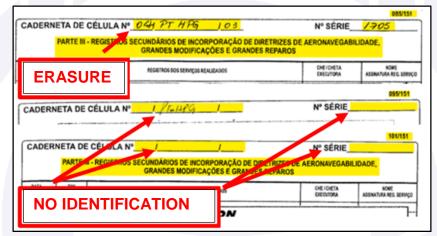
Figure 10 - Discrepancies verified in Part II of Airframe Logbook 02 / PTHPG / 03 (erasures).

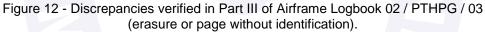
A-030/	CENIPA	/2019
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PT-HPG 11FEB2019

ĊA	DE	RNETA DE	CÉLULA Nº	1		1		N°	SÉRIE		
AF	TE	II - REGISTROS	PRIMÁRIOS DE	MANUT	ENÇÃO, INSPEÇ	ÃO, REVISÃO, P	EQUENAS I	ODIFICA	ÇÕES E PEO	UENOS R	EPAR
	ATA	TSN					CERTIFIC	O A EXECUÇÃ (seções 43.9 e	DEAAERONAV 43.11 do RBHA 4	3)	
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		MARCAS :	PT-HPG		CANTE :	BELL HELICOPTE	R MODELO	:	206 B		1
1	1	Nº DE SERIE :	1705			1975	CAT. REG		SAE		1
<i>.</i>		HORAS TOTALS	15.243.9			UNK	TIPO DA I	NSPEÇÃO :	IAM		
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1											_
_		COMPONENT	E FABRIC.	ANTE	MODELO	N* DE SÉRIE	TSN	CSN	TSO	CSO	
1	1	MOTOR 1	ROLLS R		250-C20	CAE-821758	12.809,3	6.889	N/A	N:A	-i
'		ROTOR PRINCIP			206-011-100-017	JILM-02364	14236.8	NA	582,1	N/A N/A	4
		ROTOR AUXILLA	AR BELL HELD	COPTER	206-010-810-015	AAG-50196	4.163,1	N/A	1.685,1	N/A	
1	/	liberada para o ret- vigor , em particul conformidade com obrigatório.	orno ao serviço por l	erem sido programa e provado n	ida a Inspeção Anual verificados e encontra le manutenção aprova o brasil e a disponib	idos em ordem e em ido aceito, o adequa	dia todos os re lo cumpriment	quisitos aplic o das Diretriz	aveis da regula es de Aeronavi	mentação em gabilidade, a	-
/	/	Resp. Pela Execuçã Resp. Pela Inspeçã	 Marcio Rodri; João Luiz Ma 	gues De reelino N	Jesus Cód. Anac Junes Cod. Anac	Nº 11604-0 Nº 71039-2					
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-			e agosto de 2010		self dente	1	-	Rep. p. In	specilo		
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Figure 11 - Discrepancies verified in Part II of Airframe Logbook 02 / PTHPG / 03 (no identification).





R	DOS DA AI DATA DONNEAA	TSK	DADI PART HUMBER NOMENCLATURA NUMERO DE SÉRE			TIFICATION	DTNO I CHETA
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Figure 13 - Discrepancies verified in Part IV of Airframe Logbook 02 / PTHPG / 03 (erasure or page without identification).

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014	4.6	10	153483	8087	95737	D	5915	05	1	1578.1	815 \$	957257
11/14	42	8	157235	8095.	2322	P	101/2	22	7	ISTQ3	81.61.	9591197
12 114	SH	12	15.757.7	8107.	959279	Þ	1145	28	8	152851	8167	95923
211/10	38	5	157617	6112	259137	10	12115	3.5	12	157996	8181	95723
SIL	60	9	15767.7	\$121.0	959237	b	0/116	31	6	07917	8187	959,697
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0415	2.6	10	15773.5	8137	957259	MD	03111	20	6	15.799.4	825	957239
511>	1.6	5	15775,1	8142	957239	P	04116	37	11	1583]	8216.	939,241
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ofils	17	4	15.776 ?	8146.	15747	P	01 46	13	5	158075	8337	95/19
28/15	20	7	15.7796		9591591	10	difa	0	0	158075	8227	95929

Figure 14 - Erasure in Part I of Airframe Logbook 05 / PTHPG / 12.

					017/151
CADER	RNETA DE C	ELULA Nº 051 PT-HP6 1	12		2¢/
PARTE II -	REGISTROS P	PRIMÁRIOS DE MANUTENÇÃO, INSPEÇÃO, R	EVISÃO, PEQUENAS MOI	DIFICAÇÕES E PEQI	UENOS REPAROS
DATA	TEN		CERTIFICO A	EXECUÇÃO E A AERONAVEO les 43.9 e 43.11 do RBHA 43	GABILIDADE
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018/151					
CADER	NETA DE C	ELULANO 05 1 PT. HPG	1/2	Nº SÉRIE	1705
		RIMÁRIOS DE MANUTENÇÃO, INSPEÇÃO,	REVISÃO, PEQUENAS N		
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				ARRANT	019/1
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					1705
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RTE II - RI	EGISTROS PR	IMÁRIOS DE MANUTENÇÃO, INSPEÇÃO, RI	EVISÃO, PEQUENAS MO	DIFICAÇÕES E PEQ EXECUÇÃO E A AERONAVE Ses 43.9 e 43.11 do RBHA 43 NO	QUENOS REPARO GABILIDADE 3) ME
RTE II - RI	EGISTROS PR	IMÁRIOS DE MANUTENÇÃO, INSPEÇÃO, RI	EVISÃO, PEQUENAS MOI CERTIFICO A (540)	DIFICAÇÕES E PEO EXECUÇÃO E A AERONAVE Ses 43.9 e 43.11 do RBHA 43 NO CÓDIGO DAC	1705 QUENOS REPAR(GABILIDADE 3) ME (ASSINATURA
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CADER PARTE II - RI	TSN CSN	IMÁRIOS DE MANUTENÇÃO, INSPEÇÃO, RI	CERTIFICO A CERTIFICO A CHEICHETA CHEICHETA EVISÃO, PEQUENAS MOD	DIFICAÇÕES E PEQ EXECUÇÃO E A AERONAVE les 41.9 e 41.11 do RBHA 43 códoido DAG MECÂNICO	1705 QUENOS REPARIO GABILIDADE 3) ME NSPETOR 021/151 .705 JENOS REPAROS
	TSN CSN CSN CSN CSN CSN CSN CSN CSN CSN C	IMÁRIOS DE MANUTENÇÃO, INSPEÇÃO, RI REGISTROS DOS SERVIÇOS REALIZADOS	CERTIFICO A CERTIFICO A CHEICHETA CHEICHETA EVISÃO, PEQUENAS MOD	DIFICAÇÕES E PEQ EXECUÇÃO E A AERONAVE Ses 41.5 e 41.11 do RBRA 41. 00 00 00 00 00 00 00 00 00 0	1705 NUENOS REPARIO GABLIDADE II MANIE ASSINCTURA INSPETOR 021/151 7005 ENOS REPAROS ABRUDADE

Figure 15 - Discrepancies verified in Part II of Airframe Logbook 05/PTHPG/12 (erasures on the Logbook identification).

In the maintenance records, it was possible, through the Log Cards, to identify that the compressor installed on the aircraft, SN CAC-30992F, had passed through Overhaul on 01JUL1988 (Figure 16).

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A-030/CENIPA/2019						PT-HPG	11FEB2019
I N 708M 2784 B (BAC			MAINTENANCE - OVERHA		Part IV Page No. 2 CORD		
Date	Compressor	Time Total	Remarks	Signature	Organization	8	
23-04-87.	1952.6	7.417.8	COMPRESSON BEPAIRED.		MRR	0 	
			STARTING THE ENGINE OF RESTRUCT USING THE COMPRESSOR SALT WATER CONTAMULATION SEMOVAL PROCEDURE GIVEN	Timm	1		
of the BB	0:00	1615:35	IN THE OPERATION AND MAINTENANCE MANUAL .	- Alany	MIRR		
BIOMAUS	(10:1337 C	10205-7 35N:8762	OGANIL HAWA LOLD BAT		REINASECOMPONE		
195			ART A	RONALES CO 2361	SE COMPONENTS	2	
63/12/2011	31368	107523 ISN 9242	Connector Genorge IN ACCESSAIOL		THE STATEMENTES LTD		
		ar, pla	DI DR-7 DAD ISPAC DOM	CHE \$611	S E COMPONENTES LTD BYDAC	a.	
	10 11 10	1		· · · · · · ·	Constant.		

Figure 16 - Log Card with Overhaul information on 01JUL1988.

The compressor module, SN CAC-30992F, had also been repaired due to filling, and remained, after that maintenance with 3,136.8 hours of Time Since Overhaul (TSO) and 1,817 Cycles Since Overhaul (CSO), as SEGVOO 003 n° ATC 00417/2011, dated 09DEC2011 (Figure 17).

BRASIL		NACIONAL DE AVIAÇ IBERAÇÃO AUTO VAÇÃO DE AERONAVE Formulário (Form	GABILIDADE LAND	PERMISSION CONTENTS PERENT AND A CONTENT OF A CONTENT ON THINK SAMPROVING (AND)	4 Elevidente Af Certificate of Epities datalog or y
Ar Christian Providence de Ar Christian Providence de Ar Christian Providence de Arte Christi	Nevce Turbinus o Componentes Lata Olivera 2005 - Parte - ParunahU - Ru Pantester	CHE 9611-03WMAC	ef. 55(21)2455-3199	Fax: 55(23):3010-8779 Manner III Start Lee Mark Martin - Kant Marked	A Greine de Enroqué Control 1972/011 Service Control 1972/011
1 MODULO DE COMPRE Otravasjas parataj SN:10752.3H CSN 92424	SSOR 6890550(250-C208)	TEV-INSTALLER		CACODED	Ultran / Works
MA.	IS REALIZATION, BEM COMO A REL	LAÇÃO DOS MENS SUE	ISTITUIDOS, ESTÁ	CONTIDA NOS ARQUIVOS D	A ATC SOB Á ORDEM DE SERVIÇO MENCIONADA
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Figure 17 - SEGVOO 003 nº ATC 00417/2011.

The SEGVOO 003 form should be used as a primary maintenance record and for the control and traceability of aeronautical parts. Its basic purpose was to certify the airworthiness of aircraft engines, propellers and articles¹. The uses foreseen by the form, sometimes called "label", were:

- approve the aircraft engine, propeller, or article for return to service after maintenance;
- certify the airworthiness of aircraft engines, propellers, and articles, after manufacture;

¹ According to the definition of RBAC nº. 43, Emd 04, 07AUG2019, article means an aircraft, airframe, engine, propeller, accessory, component or its parts. For the purposes of this regulation, an article has the same meaning as an aeronautical product.

- approve airworthiness for the export of aircraft engines, propellers, and articles, when required by the importing country; and

- attest to the conformity of the aircraft engine, propeller, or prototype article.

The SEGVOO 003 ATC 417/11 was listed in the monthly report of services performed by the company ATC, referring to December 2011, making it clear that the service performed by that maintenance organization was a repair on the compressor module, started on 30NOV2011 and completed on 09DEC2011 (Figure 18).

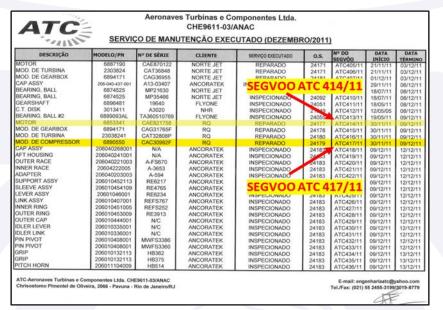


Figure 18 – Report of the ATC Maintenance Service Executed (December/2011).

It can also be seen from Figure 18 that the company ATC performed a repair service on the Gear Box and Turbine modules. The SEGVOO 003 ATC 415/11 (Figure 19) was issued for the Gear Box module, being considered the last maintenance intervention record found in the available documentation, according to inspection control in FORM 2784C (Figure 20).

It should be noted that the Gear Box module was considered a maintenance item on condition (OC).

BRASIL	CERTIFICADO DE L	VACIONAL DE AVIAÇÃO IBERAÇÃO AUTOR AÇÃO DE AERONAVEGA Formulário (Form)	IZADO (AUTHO BILIDADE (AIRW	RIZED RELEASE CER	915 (CATÉ) L TAG)	3 Centrates N Centrate d'Exponsituating et ; ATC00415/2011
ATC	ronaves Turbinas e Componentes Lida.	CUE OF IL OSTALIAO				5. Ordem de Serviço/Cuntento/Note Fiscal Work Dube: Contract es invances
Av Chrisostomo Pimente	de Oliveira, 2066 - Parte - Pavuna/RJ - Bri		65/2112455.2105	Fax: 55(21) 3019-8	8779	24178
6. Rem 7. Descripão Denil (Description)	8. Numero da Peça	9. Aplicabilidade	12 Oversidade	1. Minners de Bêner Lote	And a second sec	12. Categona / Tubatho
	(1010001/0	Ouerety)	Soval Rander / Batch Number	a	(Status / Vilus)
1 MODULO DE GE/	RBOX 6894171 (250-C208)	TBV-INSTALLER	1	C	AG31765F	REPARADO
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Figure 19 - SEGVOO 003 ATC 415/11.

-030/CENIPA/2019						PT-HPG	11FEB2019
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(Province OH Gearbox Date Since OH -27, 2596.9	Time Total	Remarks Remarks	Signature	Organization		
) 10-21	-79 467.1 1 9.79 1221.2	39261 4393.7.1 5747.3 [.	Scor Julie An Shin 1 4 2021 Repaired an many Spens. Repaired as for Mony 50 gas-	Bargare Bargare Adamba	01 Sorry 11 Bog 4/ 3933 10 Ag 12 3951 Dri 10g 12 3951		
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Figure 20 - FORM 2784C.

On May 8 and 9, 2017, the PT-HPG aircraft underwent a Special Technical Inspection (VTE), carried out by the ANAC, and the aircraft was considered "non-airworthy".

Together with the Inspection Report, a document called Non-Conformities Summary (RNC) was issued, describing the "non-conformities" found in the survey that led to the result of "non-airworthy" for the aircraft (Figure 21).

Among the non-conformities reported in the RNC, the last line of item n^o. 03 described that the 3,500-hour inspection of the SN CAC 30992F compressor was overdue.

RESUMO DAS NÃO C	ONFORMID	ADES	MARCAS
(VISTORIA DE AE	RONAVE)		PT-HPG
TIPO DE VISTORIA: VISTORIA TÉCNICA ESPECIAI	MOTIVO: VERIF	CAÇÃO DA AERONA	VEGABILIDADE
OPERADOR I - DADO	S DA AERONAVE		
RQ SERVIÇOS AÉREOS ESPECIALIZADOS LTDA	CATEGORIA DE REGISTRO S00		
BELL HELICOPTER 206B		NUMERO DE SERIE: 1705	
II – DESCRIÇÃO D	AS NÃO CONFORMID	ADES	
01 - Não foi apresentado registro da instalação do CST 20 lista de grandes modificações apresentada. (CORRIGIDO) 02 - Não apresentado registro primario (FCDA) das segui FAA 90-13-01R1; FAA 2012-14-06; FAA 2006-16-04; FA/	DURANTE A VISTORIA) ntes AD: CF 2009-34; CI	1995-19: CF 2015-02-	22: FAA 94-24-11:
03 - Mapa de controle de inspeções e componentes contro			
 Inspeção de 400h da bateria; 			
 Pesagem do extintor da cabine; Inspeção de 2400h do tail rotor trunnion; 			
 Inspeção de 100h/3m para controle de corrosão; 			
 Inspeção semanal; Inspeção de 300h/6m da carcaça do compressor (CAP, 7 	72.00.00) SN 250(201-		
Inspeção de 3500h do compressor PN 6890550, SN CAC	30992F.		
04 - Não foi identificado data da substituição do painel de 340.	audio original da aeron	ave pelo painel de audi	o Garmim GMA
05 - Parte inferior da fuselagem abaixo do tanque de com da bomba de combustível e sensores de quantidade de co	bustivel apresenta pequ mbustivel.	eno vazamento nas reg	iões de instalação
06 - Parte inferior da fuselagem contem uma antena não i	dentificada totalmente o	lanificada.	
07 - Parte inferior da fuselagem com antena de VHF apres	entando pontos de corr	osão em sua base de fix	ação.
08 - Efetuar inspeção das selagens das antenas e definir s	e há ou não necessidade	de refazer as selagens,	
OBSERVAÇÃO:			
Este relatório será submetido à apreciação da Auto posteriormente encaminhada ao operador, através constatadas, com todas as orientações necessárias.	ridade de Aviação Ci de documento oficial	vil competente para , a descrição das n	aprovação, sendo ão-conformidades
	PE DE VISTORIA		
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Osasco-SP, 09/05/2017		GGCP	
Fabricio Amaral Sigueira - SIAPE 1738236	ASSINATURA:	icio diqui	500
NOME E NUMERO DA CREDENICIAL Paulo Assis Pereira Junior - SIAPE 1741826	ASSIMATURA CHE	atter	
IV – REPRESEN	TANTE DO OPERADO	DR	
NOME E NÚMERO DA IDENTIDADE:	ASSINATURA:		
Cesar Ferreira dos Santos - CREA 5061996245			

Figure 21 - Summary of "non-conformities" found in the survey.

According to the record in the Engine Logbook, Part IV - Controlled Components Installation and Removal Records, the SN CAC 30992F compressor was removed for the reason "General Overhaul", as it had reached 3,510.1 hours of TSO (Figure 22).

Also according to this record in the Engine Logbook, the SN CAC 31284 compressor was installed on the aircraft and had not operated after the last Overhaul (TSO 0, 0 hours).

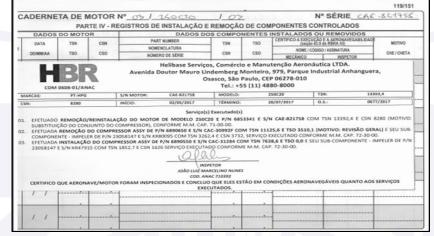


Figure 22 - Records of the CAC-30992F compressor removal for General Overhaul and installation of the CAC-31284 compressor, with TSO 0,0 hours, described on page 119/151 of the Engine Logbook made by OM HBR *Aviação SA*.

With the replacement of the compressor and proof of corrections for non-conformities, the ANAC released the aircraft on 09AUG2017, according to Official Letter nº128 (SEI)/2017/GTAI-SAR/GGCP/SAR-ANAC, dated 10AUG2017.

After the removal of the compressor by the HBR company, no record was found and/or presented that proves that the SN CAC 30992F compressor had been submitted to general review (Overhaul) after 01JUL1988.

Seventy days after the approval of the aircraft under inspection by the ANAC, the compressor set SN CAC-31284 was removed and the OM WM *Helicópteros* reinstalled the compressor set SN CAC-30992F in the engine of the PT-HPG aircraft.

According to the record made on page 120/151 of the Engine Logbook, the SN CAC-30992F compressor would have 373.3 hours of TSO (Figure 23).

				N° <u>03/250020</u> GISTROS DE INSTALAÇÃ			IDONENTES CO			20
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11		WIII	1-	SERVICOS	SERL	AL.	TSN	CICLOS	OSG:	
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	DATA DE	Tetuada remo	ção do conjunt	17/10/2017 17/10/2017 to do compressor P/N 6890550 5/h rco do compressor P/N 689650 5/h SN URK TSO 0,0 conforme PORM	DATA DE TR	ERMINO:	18 MANUAL DE MANU/TE 6,H (motivo: conver	3/10/2018 NGRO 10W2 EDITION 6 Něnciaj conforme 1	INEX. 30 BL/06/15	
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Figure 23 - Maintenance records described on page 120/151 of the Engine Logbook made by the OM WM *Helicópteros*.

The TSO hours information was also repeated in the Service Order n^o 3408, issued by the maintenance organization WM *Helicópteros*, on 18OCT2017 (Figure 24).

	Helicopteros com osot-os-anac	Ord	em de Serviço I Data: 17/10/2017	n.o. 3408		la: PT-HPG	
	Cliente: BO SER		ESPECIALIZADOS LTDA				
	Aeronave serial:	1705	TSN: 15.833,1	Pousos	/RIN: UNK		
	Motor #1	CAE-821758	TSN: 13.398,6	CY NG:	8293		
em	Produto/Serviço	-	Ação Executada		Mecànica	Inspetora of	H/H
1.	Efetuar remoção do	Efetuada remo	ção do conjunto do compress	or P/N 6890550 5/N		the start war at	1000
	conjunto do compressor		¥ 7701,6H TSO 6,H (motivo: co	inveniência) conform	ne al la s	PP - it washing	
	P/N 6890550 S/N CAC-	MM Rolls-Roya	e Cap 72-30-00		and a sto	a start	
-	31284 Efetuar instalação do				1.1		-
2.	conjunto do compressor		lação do conjunto do compres IN 11.125,6 TSO 373,3 após su		-	12 25.0	
	P/N 689650 S/N CAC-		se de P/N 23057142 S/N SET3		00	28 505 50	a .
	30992F		M ONE Nº ARCL1035950 data		10	and and all all all all all all all all all al	
			forme MM Rolls-Royce Cap 72		the Car 34	an a ger of	
hata d	de Encerramento					Condições após 5	erviço

Figure 24 - Service Order nº 3408.

Attached to the Service Order nº 3408, issued by the maintenance organization WM *Helicópteros*, there was a copy of the Card Part IV, page nº 3, of OM ATC-*Aeronaves Turbinas e Componentes* Ltd., with certification nº 9611-03, issued by the ANAC, which would have supported the installation of the SN CAC-30992F compressor set on the engine and, consequently, the release for return to service the engine and the aircraft on 180CT2017 (Figure 25).

As described in the registration of this Card Part IV, page n° 3, the OM ATC-*Aeronaves Turbinas e Componentes* Ltd. it would have performed Overhaul on the SN CAC-30992F compressor on 08DEC2011, with the compressor having 10,752.3 total hours of operation and 9,424 cycles and, from that date, its TSO would start counting a new cycle, that is, considering the maintenance program manufacturer, it would have 3,500 hours until the next overhaul.

This document also mentions, in the Remarks area, the Work Order (W/O) nº 24177 for details of the work performed.

FORM 2784 8			MAINTENANCE – OVERH COMPRESSOR ASSEMBLY	AUL REC	
ompress	for Serial I	Number	CAC - 3 0992 F Engine M	odel 250c20	
Date	Compressor Since OH	Total	Remarks	Signature	Organization
08/12/11	0.0 су	924264	COMPRESSOR OVER HALLED IN		
	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	Sales -	A CLOR DANCE WITH THE LATEST	le l	- anthico
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Figure 25 - Card Part IV, page nº 3 of the compressor set (document attached to service order nº 3408, of 18OCT2017, issued by the maintenance organization WM *Helicópteros*).

Due to the OM ATC-*Aeronaves Turbinas e Componentes* Ltd., issuer of the Service Order, having its OM Certificate suspended by the ANAC since 16JAN2015, it was not possible to recover of the W/O at the company and no records were found in the documentation delivered by the operator's responsible.

However, when consulting the monthly report of services performed by the ATC company for December 2011, it was possible to identify that the W/O 24177 referred to the SEGVOO 003 ATC 414/11, which attested the return to service, after maintenance, of the complete engine and not for the compressor module (Figure 26). In addition, the monthly report still contained the following information in the "service performed" area: REPAIRED (Figure 18).

	RASIL	A Configuration of South and of Particle Strategy (C)				
(required at the set of the set o	ALC AND ALC	s Turbinas o Componentes Ltd	Formulário (Form			ATC20414/2011 4. Online de Serviça/Cantendidas Facal plitot Celle. Cestração insular;
	Av Obtiscelomo Pimeneri de Oli 2. Besolute dimonitori	R. Stantani du Peça (Post Nandani)	Anto additionals and additionals	18 Ocentralin 11, In Ocentral Internation	55(21) 3019-8279 Insere de Salad Lole Oserber i Basile Roedan	B. Congress / Tratalian
1	MOTOR	250-C208	TOV-INSTALLER	1	CAE821758	REPARADO
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Figure 26 - SEGVOO 003 nº ATC 00414/2011.

No record was found in the copies of SEGVOO 003 nº ATC 00417/2011 (Figure 17) and nº ATC 00414/2011 (Figure 26) that mentioned any Overhaul service performed on the compressor CAC-30992F by the OM *Aeronaves Turbinas e Componentes* Ltd.

When consulting the entry and exit control of items (Figure 27), dated 09DEC2011, from the ATC Maintenance Organization, it was possible to observe that the compressor module entered and left the company with 3,136.8 hours of TSO. This corroborated the information that the last Overhaul performed on the compressor module occurred on 01JUL1988.

ATC		FABRICANTE: Allison		MODELO: 250-C20B CLIENTE:TUCSON			IA:	2A
Teller.	S/N: CAE821758		CLIEN				1/1	
CHE 9611-ANAC	PE	ÇAS ROTATIN	AS COM	AS COM VIDA LIMITADA			A: 09/12/2	011
	FASE: CONTROLE					:TA20P2		
		EN	TRA	DA		200	11103	
DESCRIÇÃO	P/N	S/N	TSN	LIMITE	SALDO	CSN	LIMITE	SALDO
Módulo de Compressor	6890550	30992F	10752.3	TSO:3136.8	363.2	9242	N/A	N/A
Módulo de Turbina	23038241	32808P	5794.0	TSO2328.0:	1172.0	8445	N/A	N/A
Módulo de Gearbox	6877180	31765F	13019.1	TSO:9093.0	O/C	N/A	N/A	N/A
Impeller Assy	23058147	KR80095	2889.2	3550.0	660.8	2872	9150	6278
1st Stg. Turbine Wheel	6886407	X553881	626.6	1775.0	1148.4	560	3000	2440
2nd Stg. Turbine Wheel	6898782	X510249	1315.7	1775.0	459.3	1599	3000	1401
3rdStg. Turbine Wheel	23001967	X79829	2328.0	4550.0	2222.0	3195	6000	2805
4thStg. Turbine Wheel	6853279	HX67507	2328.0	4550.0	2222.0	3195	6000	2805
TIE BOLT	23068265	NM89244	626.6	N/A	N/A	560	9000	8440
OBSERVAÇÕES:	20000200	1111002-11	020.0	1975	1.00	000	0000	0440
			e de Pro	odução	_			
		Gerent CREA/F	e de Pro RJ 80-1-	odução 02114D			1	
DESCRIÇÃO	P/N	Gerent CREA/F	e de Pro	odução 02114D	SALDO	CSN	LIMITE	SALD
	P/N 6890550	Gerent CREA/F	AÍD	odução 02114D	SALDO 363.2	CSN 9242	LIMITE	
Módulo de Compressor		Gerent CREA/F	AID	A LIMITE				N/A
Módulo de Compressor Módulo de Turbina	6890550	S/N S0992F	e de Pro RJ 80-1-	Odução 02114D LIMITE TSO:3136.8	363.2	9242	N/A	N/A
Módulo de Compressor Módulo de Turbina Módulo de Gearbox Impeller Assy	6890550 23038241	Gerent CREA/F S/N 30992F 32808P	e de Pro RJ 80-1- TSN 10752.3 5794.0	Codução 02114D	363.2 1172.0	9242 8445	N/A N/A	N/A N/A N/A
Módulo de Compressor Módulo de Turbina Módulo de Gearbox	6890550 23038241 6877180	Serent S/N 30992F 32808P 31765F	AID TSN 10752.3 5794.0 13019.1	A LIMITE TSO:3136.8 TSO:328.0 TSO:9093.0	363.2 1172.0 O/C	9242 8445 N/A	N/A N/A N/A	N/A N/A N/A 6278
Módulo de Compressor Módulo de Turbina Módulo de Gearbox Impeller Assy 1st Stg. Turbine Wheel	6890550 23038241 6877180 23058147	Gerent CREA/F S/N 30992F 32808P 31765F KR80095	AID/ TSN 10752.3 5794.0 13019.1 2889.2	A LIMITE TSO:3136.8 TSO:328.0: TSO:9093.0 3550.0	363.2 1172.0 0/C 660.8	9242 8445 N/A 2872	N/A N/A N/A 9150	N/A N/A N/A 6278 2440
Módulo de Compressor Módulo de Turbina Módulo de Gearbox Impeller Assy 1st Stg. Turbine Wheel	6890550 23038241 6877180 23058147 6886407	Gerent CREA/F 30992F 32808P 31765F KR80095 X553881	e de Pro RJ 80-1- TSN 10752.3 5794.0 13019.1 2889.2 626.6	A LIMITE TSO:3136.8 TSO:3228.0: TSO:9093.0 3550.0 1775.0	363.2 1172.0 O/C 660.8 1148.4	9242 8445 N/A 2872 560	N/A N/A 9150 3000	N/A N/A 6278 2440 1401
Módulo de Compressor Módulo de Turbina Módulo de Gearbox impelier Assy 1st Stg. Turbine Wheel 2nd Stg. Turbine Wheel	6890550 23038241 6877180 23058147 6886407 6898782	Gerent CREA/F 30992F 31765F KR80095 X553881 X510249	e de Pro RJ 80-1- TSN 10752.3 5794.0 13019.1 2889.2 626.6 1315.7	A LIMITE TSO:3136.8 TSO:328.0 TSO:9093.0 3550.0 17775.0	363.2 1172.0 0/C 660.8 1148.4 459.3 2222.0	9242 8445 N/A 2872 560 1599	N/A N/A 9150 3000 3000	N/A N/A 8278 2440 1401 2805
Módulo de Compressor Módulo de Turbina Módulo de Gearbox Impeller Assy 1st Sg. Turbine Wheel 2nd Stg. Turbine Wheel 3rd Stg. Turbine Wheel	6890550 23038241 6877180 23058147 6886407 6898782 23001967	Gerent CREA/F 30992F 32808P 31785F XR80095 X553881 X510249 X79829	e de Pro RJ 80-1 TSN 10752.3 5794.0 13019.1 2889.2 626.6 1315.7 2328.0	A LIMITE TSO:3136.8 TSO:3093.0 1775.0 1775.0 1775.0 4550.0	363.2 1172.0 O/C 660.8 1148.4 459.3	9242 8445 N/A 2872 560 1599 3195	N/A N/A 9150 3000 3000 6000	SALDO N/A N/A 82440 1401 2805 2805 8440

Figure 27 - ATC Maintenance Organization item entry and exit control document.

1.7 Meteorological information.

The meteorological conditions at the accident site were favorable for the visual flight, as observed in the security camera of SP-021 Highway (Figure 28).

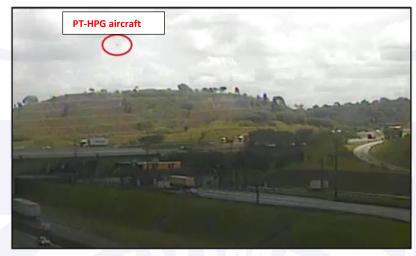


Figure 28 - Image from the security camera just before the accident.

The METAR of the Campo de Marte Aerodrome (SBMT), 11.3 NM away from the accident site, contained the following information:

METAR SBMT 111300Z 31009KT 9999 BKN033 28/19 Q1018= METAR SBMT 111400Z 29010KT 9999 BKN036 28/19 Q1017= METAR SBMT 111500Z 30009KT 9999 BKN040 30/20 Q1016= METAR SBMT 111600Z 30011KT 270V340 9999 BKN040 30/19 Q1016=

The METAR of the Viracopos Aerodrome (SBKP), 9 NM away from the Amarais Aerodrome and 5.5 NM away from the Royal Palm Plaza Helipad, contained the following information:

METAR SBKP 111300Z 35012KT 9999 SCT026 BKN100 27/20 Q1018= METAR SBKP 111400Z 33011KT 9999 SCT033 SCT100 29/20 Q1017= METAR SBKP 111500Z 36010KT 9999 BKN036 30/19 Q1016= METAR SBKP 111600Z 32012KT 9999 BKN040 31/19 Q1015=

1.8 Aids to navigation.

Nil.

1.9 Communications.

Nil.

1.10 Aerodrome information.

The occurrence took place outside the Aerodrome.

1.11 Flight recorders.

Neither required nor installed.

1.12 Wreckage and impact information.

The aircraft was hit on its left side, in flight, by a truck-type vehicle and broke into four parts: main Gearbox (CTP), blades, engine, fuselage and tail boom.

After the collision, a fire completely destroyed the fuselage and partially destroyed the main Gearbox (CTP), blades and engine.

The tail boom, after being sectioned, was not affected by the flames and had small deformations resulting from the impact.

The truck's braking marks identify where the vehicle would have hit the aircraft. It is clear that the approach of the helicopter for the attempted autorotation was very close to the highway protection wall (Figure 29).



Figure 29 - Approximate impact location.



Figure 30 - Aircraft journey.



Figure 31 - Aircraft journey and probable area chosen by the pilot for autorotation.



Figure 32 - Place where the aircraft passed (between lanes).

1.13 Medical and pathological information.

1.13.1 Medical aspects.

The commander carried out his last health inspection in an accredited clinic in São Paulo - SP, on 07AUG2018 without presenting abnormalities. There was only the indication to use corrective lenses.

The analysis of the necroscopic report revealed external injuries of medical-legal interest, which indicated that the cause of death was due to head trauma, in consequence of the injuries received, with secondary carbonization.

The blood sample was negative for the use of ethyl alcohol and drugs, in addition to medicines. The measurement of carbon monoxide detected a concentration below 10% of carboxyhemoglobin in the blood, indicating that the pilot was already dead before exposure to the gas.

1.13.2 Ergonomic information.

Nil.

1.13.3 Psychological aspects.

According to information collected, the pilot was one of the owners of the company to which the aircraft involved in the incident belonged.

According to the reports obtained, he had personally carried out the negotiations concerning the performance of that transfer flight. The company's operational coordination became aware of this charter one week before the scheduled date. According to the interviewees, accepting jobs outside the company's operational specification was not the pilot's usual behavior.

However, people close to him reported that the acceptance of this air taxi flight might have occurred for financial reasons, as the company was in low demand for jobs at the time, flying about three and a half hours a month, which left the pilot worried.

He worked on Saturdays, Sundays and holidays to cover financial obligations. He kept the office phone transferred to his cell phone on weekends so as not to miss the opportunity to make new flights that might appear.

The pilot spent the weekend, before the day of the incident, on his farm in the countryside of São Paulo, returning on Sunday afternoon. He arrived at the Campo de Marte Aerodrome on 11FEB2019, at about 0945 (UTC), and the displacement to the passenger boarding place was scheduled to happen at 1100 (UTC).

The company's Safety Manager (GSO) was only aware of the flight with the news of the occurrence passed on by the company's coordination. In his view, the pilot mastered the aircraft, was a detailed person, careful with the equipment and piloting, and tried to keep up with updated aviation knowledge.

Other professionals in the field, close to him, defined him as an excellent pilot, systematic, careful and skilled with helicopters. He was well-liked by colleagues who also worked at Campo de Marte.

It's been informed that he did not drink, had no addictions and kept a good professional relationship.

The GSO worked at RQ *Serviços Aéreos Especializados* Ltd. for 9 months, but he had known the pilot for 20 years. There was an open and friendly relationship between them.

1.14 Fire.

After being hit by the truck, the aircraft broke down and caught fire.

The fuselage and the tail boom were on the highway, the engine and the main Gearbox (CTP) and blades were tossed to the central reservation.

The wreckage was divided by a concrete wall (Figure 33)



Figure 33 - View of the fuselage remains and the soot marks on the concrete wall.

The fuselage was consumed by the fire and the marks left by the soot on the wall showed a random burning, compatible with fire after the impact.

The tail boom was not subjected to the action of fire, as it was removed from the rest of the aircraft structure.

1.15 Survival aspects.

There were no survivors.

1.16 Tests and research.

Due to the destruction of the aircraft and the action of the fire, it was not possible to collect samples that were in the fuel system at the time of the accident, as well as there was not enough oil in the engine to perform spectrometric analysis, since it was pulled out of its mounting, as a result of the impact, and also the system lines were open.

Thus, six samples of Aviation Kerosene (QAv) were collected from the fixed tank and from the fuel supply truck of the distributor that carried out the last refueling of the aircraft at the Campo de Marte Aerodrome.

The IAE's Aeronautical Propulsion Subdivision performed the physical-chemical tests of aspect; corrosivity to copper (100°C/2 hours); flash point; specific mass at 20° and fuel distillation to check compliance with the values specified by the ANP Resolution.

The results obtained with the tests showed that the material of all samples were in accordance with their technical specifications and did not show any signs of contamination.

The connecting shaft of the engine accessories box to the tail rotor (Figure 34) was found sectioned and the part was sent for fracture analysis at the DCTA.



Figure 34 - Connecting shaft between the "Gearbox" and the tail rotor.

The results of the tests, carried out at the IAE's AMR, based at the DCTA, indicated, after visual and stereoscopic examinations, rupture due to overload applied to the material.

The flexible blades had different aspects between the side referring to the tail rotor and that one of the freewheel outlet (Figure 35).

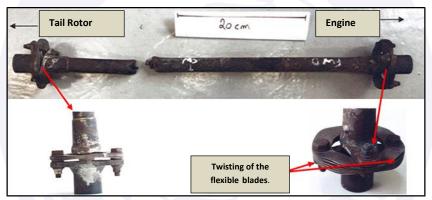


Figure 35 - Twist of the flexible coupling blades of the tail rotor/Gearbox connection shaft.

The conditions found, showed a possible locking of part of the shaft connected to the tail rotor and a continuous rotation of part of the shaft connected to the Gearbox and, consequently, to the freewheel assembly.

The fractures found in the connection shaft of the engine Gearbox to the tail rotor had different morphologies. The side referring to the tail rotor showed a morphology called fish mouth (Figure 36 - IV), while the engine side showed a spiral morphology (Figure 36 - V).



Figure 36 - Connecting shaft between the "Gearbox" and the tail rotor.

The morphology of the connection shaft fracture, with rupture without helical deformation on the connection side with the tail rotor and with deformation on the output side of the Gearbox, indicated that the shaft was rotating at the moment of the collision with the truck. The rotation of the axle did not necessarily indicate engine operation, since the freewheel system kept the rotation of the shaft while the main rotor was spinning, even with the engine inoperative.

The M250-C20 engine, serial number CAE 821758, which equipped the PT-HPG aircraft, was transported to an OM holder of a valid Maintenance Organization Certificate (COM). The Operating Specifications (EO) of the OM allowed maintenance actions on this engine.

Two Rolls Royce technical representatives and a representative of the Investigation Team accompanied the dismantling activities of the engine and its parts.

During the analysis of the general condition of the engine, it was observed that it was locked and its color showed that it was exposed to high external temperature (Figure 37).

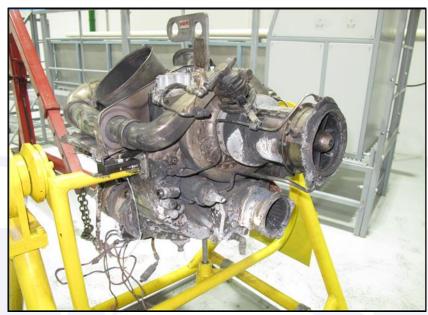


Figure 37 - External condition observed in the engine that equipped the PT-HPG aircraft.

When analyzing the fuel system, no impurities were observed in the filter elements.

The Fuel Control Unit (FCU) and the Power Turbine Governor (PTG) were damaged due to exposure to heat, but no apparent anomalies or functional discrepancies were found.

The fuel injector nozzle (Fuel Nozzle) and bleed valve (Bleed Valve) were examined externally and no blockages or damage were observed.

The fuel pump was exposed to high temperatures, as evidenced by its color, and was blocked, possibly by exposure to fire. (Figure 38).



Figure 38 - Fuel Pump.

When disassembling and analyzing the compressor section, no sign of material ingestion was found and, even after separating the compressor module from the Gear Box, the compressor remained locked (Figure 39).



Figure 39 - Front view of the axial compressor air intake.

No compromise was observed for the stator and rotor blades (Figures 40 and 41).



Figure 40 - Stator blades intact.

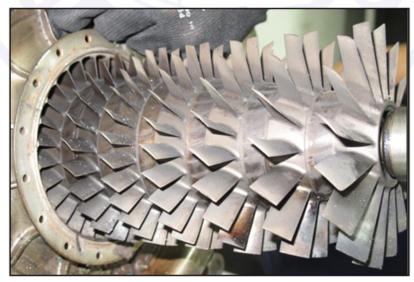


Figure 41 - Rotor blades intact (axial compressor impeller).

The impeller of the centrifugal compressor showed material loss in part of the disc diameter (Figure 42) and rubbing in part of the carcass (Shroud) that surrounded the impeller (Figure 43).



Figure 42 - Loss of material from the centrifugal compressor impeller.



Figure 43 - Scratch marks on the centrifugal compressor housing (Shroud).

During the separation of the compressor section and the Gearbox, bearing n^o 2 was found locked and with the ball separator fractured in several parts (Figures 44 and 45).

It was possible, through the markings on bearing n^o 2, to identify that it was a Parts Manufacturer Approval (PMA) component, with design and production approved by the (FAA), manufactured by Timken Alcor Aerospace Technologies Inc.



Figure 44 - Bearing n^0 2 with the fractured ball separator.



Figure 45 - Fractured ball separator.

The balls of bearing nº 2 showed abnormal wear and were ovalized (Figure 46).



Figure 46 - Balls of bearing n° 2 worn and ovalized.

Color variation was visually observed in the ball separator of the bearing (Figure 47).

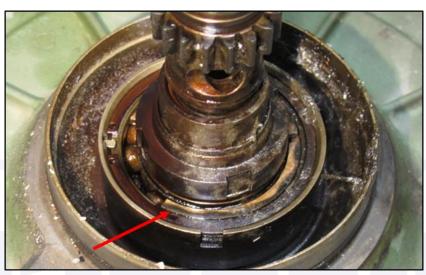


Figure 47 - Color change due to exposure to high temperatures.

Bearing n^o 2 was subjected to stereoscopic examinations at the DCTA, and it was evidenced wear and loss of material in the external and internal bearing tracks (Figure 48).

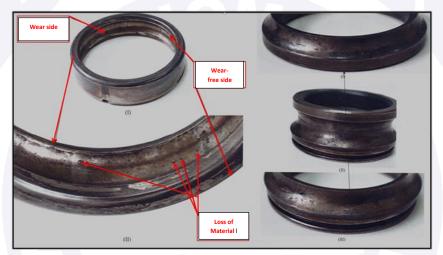


Figure 48 - External and internal tracks with wear and loss of material.

In addition, the analyzes carried out on the bearing showed that the fracture occurred by an overload mechanism, without any evidence of fatigue in the material.

When analyzing the lubrication system and the Gearbox, it was found that the filter element of the low-pressure oil return filter (Scavenge Oil Filter) was dry and covered with soot and also metallic powder residues were found inside the container, however, there were not enough fragments and sizes to block the oil passage and activate the by-pass system.

The oil pressure filter was visually inspected and no dirt / wreckage or foreign material was observed. The residual oil contained in the oil pressure filter container was apparently clean, with normal color and smell (Figure 49).

PT-HPG 11FEB2019



Figure 49 - Oil pressure filter and the filter container.

The upper and lower Magnetic Chip Detectors contained a significant amount of apparently ferrous material, covered by an oily substance similar to gel (Figure 50).



Figure 50 - Metallic material deposited on the Magnetic Chip Detectors.

The X-ray fluorescence analysis (XRF) was performed on the residues collected at the active ends (A and B) of the auto switches and the results are as follows in Figure 51:

Element	A	B	M50 Specification	
Liement	W	t.%	min	max
Cr	5	4.5	3.75	4.25
Mo	3.8	4	4.0	4.5
V	0.9	0.6	0.9	1.1
Mn	0.3	0.5	0.0	0.35
Fe	89	87	remainder	
Ag	0.9	0.8	-	

Figure 51 - Results of the XRF analysis of the material collected at the ends of the auto switches (A and B) and the specification limits for a bearing material (M50 Specification).

The composition of the collected residue was consistent with the material of the bearing. The iron alloy elements present suggested materials similar to those of the M50 bearing. The analysis also detected traces of silver, which was consistent with the material used to cover the bearing separators.

Continuity testing was performed on the magnetic chip detectors using a multimeter. The tests confirmed that the space resistance at the tip of the detectors was significantly less than the value specified for a clean detector, indicating that the circuits of the detectors were linked, that is, connected (electrical continuity).

The Gearbox had thermal damage on its bottom exterior. It was opened and burnt oil residues, dark colored in its internal components, were observed (Figure 52).



Figure 52 - Gearbox.

The oil pump was dismantled, but no apparent abnormalities were found, only residual oil burned, which prevented its operation, locking its gears and axles.

The oil delivery tube, PN 6851505 and SN BN 13509, was visually inspected and it was found that there were residues of foreign material in the orifice responsible for supplying oil for lubrication of bearing n^o 2.

A test was carried out, introducing oil at low pressure, and it was verified that there was no fluid coming out of the hole that directed the lubrication to bearing 2 (Figure 53).

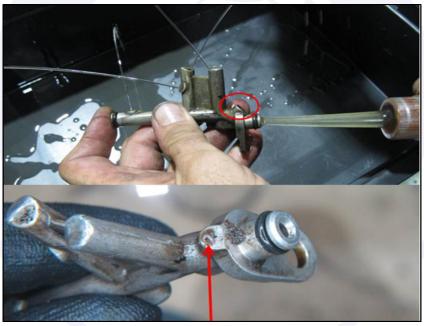


Figure 53 - The oil delivery tube with blocked orifice.

The detailed examination in the orifice that injected oil in bearing n^o 2, carried out using the Scanning Electron Microscope (MEV), confirmed that there was the presence of material obstructing the duct responsible for the lubrication of bearing n^o 2.

The material was examined by X-Ray Spectroscopy (EDS) and the results indicated that the blocking material was carbonaceous (Figure 54).

Carl Sin	Element	Wt. %
The Bargha	С	58
A CARA	0	38
C Yzd	Р	0.2
	Mg	3
Server Start Co	CI	0.6

Figure 54 - Results of the EDS analysis.

The material was partially volatile under vacuum, through the MEV analysis, as evidenced by a morphological change after approximately 15 minutes of exposure to vacuum.

An additional analysis was performed after the morphological alteration and there was no considerable compositional difference in the material. Traces of phosphorus and approximately 3% of magnesium were found in the material (Figure 55).

	Element	Wt. %
	С	59
	0	37
575	Р	0.3
	Mg	3
the states	CI	0.5

Figure 55 - Results of the EDS analysis of the material that blocked the orifice of the oil delivery tube for bearing n° 2, after exposure to vacuum.

The oil delivery tube was subjected to an inspection by Computed Tomography (TC) to assess the extent of the blockage in the passage of the oil jet to bearing n^o 2.

The block found in the oil delivery tube filled the entire cross-sectional area and approximately half the length of the oil passage duct for bearing n^o 2. There were no variations in intensity on the TC that could have suggested variation in the composition or block density along its length (Figures 56 and 57).

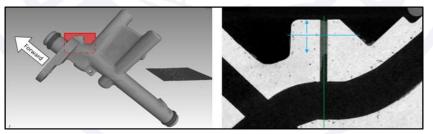


Figure 56 - Result of TC performed on the oil delivery tube. A 2D section along the red plan is shown in detail.

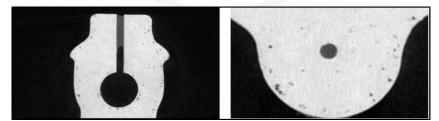


Figure 57 - 2D sections along the plans shown in Figure 56.

Considering what was prevised in the Operation and Maintenance Manual (OMM) RR M250-C20, which required that oil changes to be carried out every 600 hours or 12 months, whichever came first, and in comparison with the maintenance records contained of the available Engine Logbook, it was found that the calendar change interval was exceeded several times, as can be seen in Figure 58.

Data·da·Troca· do·Óleo¤	Horas∙do•Motor¤	Tempo• Calendárico•¤	Horas∙ Decorridas¤	Óleo•Utilizado¤
25/07/2003¤	11879.5¤	ğ	д	MOBIL-254g
18/03/2004¤	11896.2¤	7.9¤	16.7¤	BP-2197¤
22/10/2004¤	11983.6¤	6.9¤	87.4¤	BP-2197¤
17/07/2006¤	12227.2¤	<mark>20.9</mark> ¤	243.6¤	BP-2197¤
06/02/2007¤	12305.1¤	6.7¤	77.9¤	BP-2197¤
26/11/2007¤	12423.7¤	8.7¤	118,6¤	BP-2197¤
12/08/2008¤	12505.4¤	8.5¤	82.0¤	BP-2197¤
14/08/2009¤	12637.2¤	11.9¤	131.8¤	MOBIL·254¤
18/08/2010¤	12809.3¤	<mark>12.3</mark> ¤	172.1¤	MOBIL·254¤
08/11/2013¤	13246.5¤	<mark>38.7</mark> ¤	437.2¤	MOBIL·254¤
27/03/2015¤	13335.3¤	<mark>16.6</mark> ¤	88.8¤	MOBIL·254¤
20/07/2017¤	13392.4¤	<mark>27.8</mark> ¤	57.1¤	MOBIL·254¤
16/05/2018¤	13416.1¤	9.9¤	23.7¤	MOBIL·254¤

Figure 58 - Engine oil change history (Calendar time given in months).

It is observed that the Mobil 254 oil was used in 2003 and from 2009 on. Between 2004 and 2008, the BP 2197 oil was used. This replacement does not cause problems, as long as the change is complete (that is, it is not recommended the mixture of these oils).

Bearings nº 1, 2½, 3, 4, 5, 6, 7 and 8 had normal operating conditions.

There was no evidence of irregular burning in the combustion chamber. All components, liner and case, showed a normal and uniform firing pattern, as well, no damage was found in the set of shield and stator blades, although the shield had a rough surface, probably due to material coming from the compressor rubbing (Figures 59 and 60).



Figure 59 - "Liner" of the combustion chamber.



Figure 60 - Shield, stators and combustion chamber case.

During the analysis of the turbine section, all stages of the turbine and set of stator blades were intact, showing no mechanical damage or signs of temperature extrapolation.

There was soot all along the gases path and oil sludge in the oil collector on bearing n° 8.

The turbine bearings were intact. The supports of the power and gases generator turbines were undamaged and with a normal operating appearance. The turbine shaft was connected and showed no warping or damage.

Research was also carried out on the aircraft's alarm lights panel (Warning and Caution Lights) and on the engine oil pressure and temperature indication instrument (ENG OIL).

The engine oil pressure and temperature indication instrument did not show signs of impact of the measuring pointers against the reading surface, and not being possible to determine their position at the time of the accident (Figure 61).

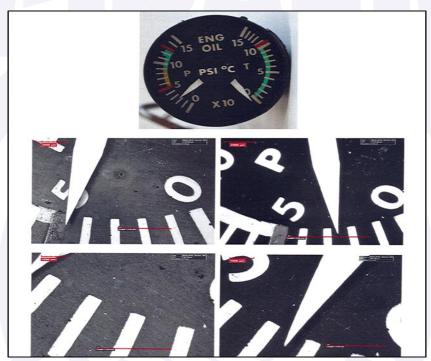


Figure 61- There were no marks on the face of the dial indicating the impact of the hand.

As for the panel of warning lights (Warning and Caution Lights), each lighting space (slot) was composed of two lamps, which were subjected to stereoscopic exams (Figure 62).

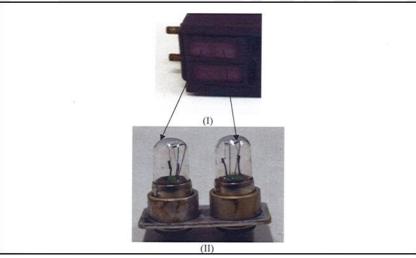


Figure 62 - Each slot consisted of two lamps.

The identified positions from I to VIII and XI did not have a warning function, being called spare (Figure 63).

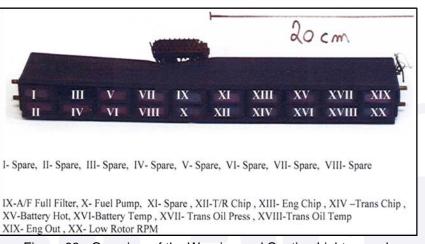


Figure 63 - Overview of the Warning and Caution Lights panel.

When observing the filaments of the lamps in the Warning and Caution Lights panel, it was found that both lamps in the IX-A / F Full Filter slots, X-Fuel Pump, XII-T / R Chip, XV-Battery Hot, XVIII -Trans Oil Temp and XIX-Eng Out did not show filament rupture and had normal deformation caused by use (Figures 64, 65 and 66).

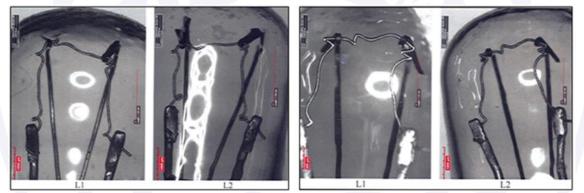


Figure 64 - Normal deformation caused by the use of lamp filaments in slots IX-A / F Full Filter and X-Fuel Pump.

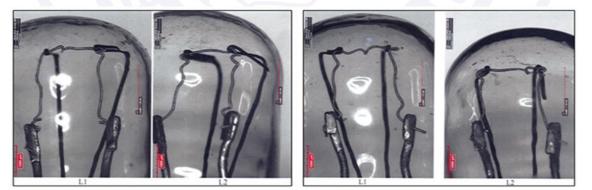


Figure 65 - Normal deformation caused by the use of lamp filaments in slots XII-T / R Chip and XV-Battery Hot.

PT-HPG 11FEB2019

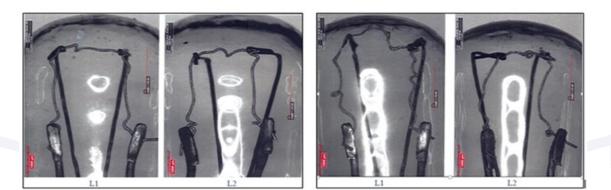
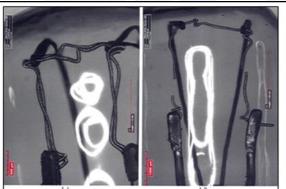
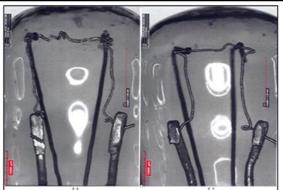


Figure 66 - Normal deformation caused by the use of lamp filaments in slots XVIII-Trans Oil Temp and XIX-Eng Out.

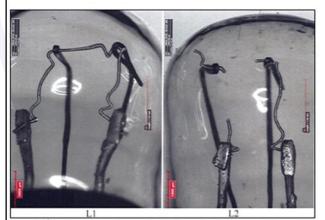
It was observed that one of the lamps in the XIV-Trans Chip, XVI-Battery Temp, XVII-Trans Oil Press and XX-Low Rotor RPM slots showed a filament rupture (Figure 67).



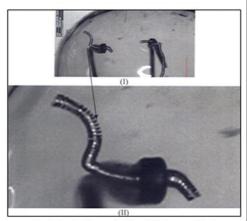
XIV-Trans Chip: filamento da lâmpada L1 íntegro e L2 rompido.



XVII-Trans Oil Press: filamento da lâmpada L1 rompido e L2 íntegro.



XVI Battery Temp: filamento da lâmpada L1 íntegro e L2 rompido.



Detalhe da lâmpada L2 e detalhe ampliado.



XX-Low Rotor RPM: filamento da lâmpada L1 rompido e L2 íntegro.

Figure 67 - Slots that presented one of the two lamps with broken filament.

The two lamps in the slot referring to the XIII-Eng Chip position had their filaments broken with no sign of elongation (Figures 68 and 69).

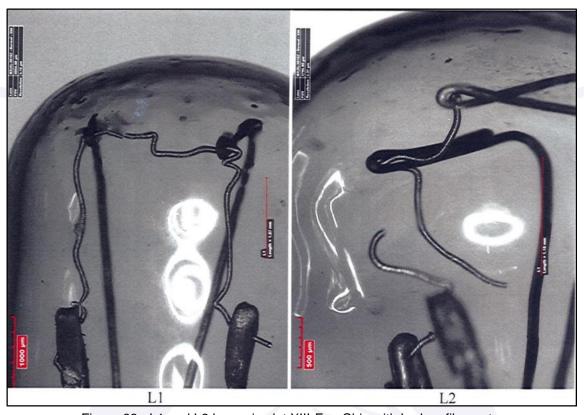


Figure 68 - L1 and L2 lamps in slot XIII-Eng Chip with broken filaments.

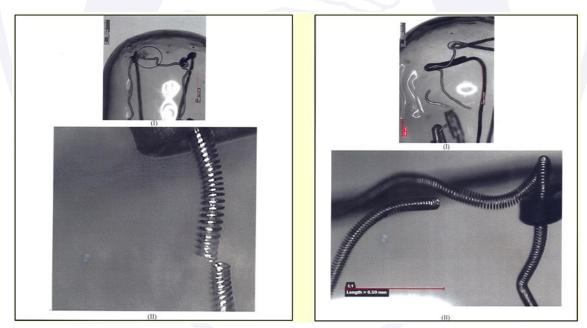


Figure 69 - Details of the broken filaments of the L1 and L2 lamps in slot XIII-Eng Chip.

All lamps in the panel showed deformation compatible with use, with no evidence of rupture with hot deformation.

1.17 Organizational and management information.

The company, considered small, was composed by two owners (the pilot, who died in the occurrence and his son), the GSO and the flight coordinator.

It also had another pilot, without a formal employment contract, to operate the Robinson R22 and R44 helicopters. The Bell "Jet Ranger" (helicopter of the occurrence) was operated exclusively by the pilot-owner and belonged to the company since 2003.

In the last nine months, after hiring the new person responsible for the GSO, weekly meetings were held to discuss matters related to safety with the members of the company. The report of this person responsible for the GSO points out that he was present at the company every Tuesday; on other days, management was done remotely.

The pilot-owner had changed the company responsible for carrying out the maintenance of the aircraft in 2017. In the perception of the GSO, the contracted maintenance company met what was expected from the work performed and determined by the operator.

The company, in the last months of operation, had been performing about three and a half hours of monthly flight, alternating the aircraft. The pilot-owner was considered to be very focused on company matters and followed everything related to it, according to employees' statements.

The organizational climate was considered very good, due to the fact that there is also a family and friendship bond between the owner and the employees.

According to information posted on the ANAC website, through a press release, the operator RQ *Serviços Aéreos Especializados* Ltd. he was authorized to provide Specialized Aircraft Services (SAE), which included aerial photography, aerial reporting, and aerial cinematography, among others in the same industry.

The operational authorization to operate a public air service specialized in aero report, aero photography, aero cinematography activities had been renewed on 03JUL2015, for five years, in the decisions published in the Union Official Journal of 06JUL2015.

The ANAC Note also stated that the company could only transport passengers, provided that the activity was unpaid and related to the specialized services for which it was authorized (Figure 70).

Nota atualizada em 12/2/2019, às 09:27.
Brasilia, 11 de fevereiro de 2019 – A Agência Nacional de Aviação Civil (ANAC) informa que, segundo dados do Registro Aeronáutico Brasileiro (RAB), o helicóptero acidentado nesta segunda-feira (11), em São Paulo, estava com o Certificado de Aeronavegabilidade (CA) válido até maio de 2023 e a Inspeção Anual de Manutenção (IAM) em dia até maio de 2019, ou seja, a aeronave estava em situação regular.
O helicóptero, de matrícula PT-HPG, da fabricante Bell Helicopter, era de propriedade da RQ Serviços Aéreos Especializados LTDA. Esse modelo é um monomotor com capacidade máxima de quatro passageiros mais a tripulação.
De acordo com informações oficiais da Aeronáutica, o piloto a bordo da aeronave era Ronaldo Quatrucci. As licenças e habilitações dele, de piloto comercial de helicóptero (PCH), estavam válidas. Estava a bordo do helicóptero também o jornalista Ricardo Boechat.
As investigações sobre as causas do acidente estão sendo conduzidas pelo Quarto Serviço Regional de Investigação e Prevenção de Acidentes Aeronáuticos (SERIPA IV), órgão regional do Centro de Investigação e Prevenção de Acidentes Aeronáuticos (CENIPA), do Comando da Aeronáutica.
A ANAC se solidariza com os familiares das vítimas do acidente e colabora com as investigações que estão em curso.
Abertura de processo e tipo de operação da empresa
A empresa RQ Serviços Aéreos possui autorização para prestar Serviços Aéreos Especializados (SAE), que incluem aerofotografia, aeroreportagem, aerocinematografia, entre outros do mesmo ramo. Por essa modalidade, a empresa pode realizar o transporte de passageiros, desde que a <u>atividade não seja remunerada</u> e esteja relacionada aos serviços de aerofotografia, aeroreportagem, aerocinematografia, entre outros do mesmo ramo. A ANAC abriu procedimento administrativo para apurar o tipo de transporte que estava sendo realizado no momento do acidente.
Em 2011, a empresa RQ Serviços Aéreos foi multada pela ANAC por veicular propaganda oferecendo o serviço de voos panorâmicos em aeronave e por meio de empresa não certificada para a atividade. O serviço só pode ser executado por empresas e aeronaves certificadas na modalidade táxi-aéreo. A multa, no valor de R\$ 8 mil, foi paga.

Figure 70 - Note published on 11FEB2019 on the ANAC website.

Also according to the Note, the RQ *Serviços Aéreos Especializados* Ltd. had been fined, in 2011, for offering the panoramic flight service, which could only be performed by companies and aircraft certified in the TPX – Air Taxi category, in accordance with RBAC 135.

In order to operate in accordance with RBAC 135, it would be necessary that, in addition to the COA, issued on behalf of the certificate holder and the authorization to provide remunerated public air transport services for passengers or cargo, the operator had submitted a training program approved by the ANAC, which would ensure adequate training to perform the duties of each crewmember, among other obligations.

The RQ Serviços Aéreos Especializados Ltd. did not have an approved operational training program and was not certified by the ANAC, according to the RBAC 135, and did not have authorization to provide remunerated public air transport services for passengers or cargo.

The RQ Serviços Aéreos Especializados Ltd. website, at the time of the accident, offered the following services: aerial photographs, aerial shooting, aerial reports, air taxi, aerial searches, aerial inspections, weddings, panoramic flights, escorts, transportation of valuables and events (Figure 71).



Figure 71 - Services offered at the RQ Serviços Aéreos Especializados Ltd. http://www.rqhelicopteros.com.br/.

The company *Zum Brasil*, which operated in the corporate events sector, coordinated the landing authorization at the Royal Palm Plaza Helipad (SSQW) on 11FEB2019 for the passenger to disembark at 1300 (UTC) and to re-boarding at 1530 (UTC).

The company Zum Brasil, through a press release, made the following statement:

... "For the displacement of the journalist [...] to participate in a convention of a pharmaceutical laboratory in Campinas, *Zum Brasil* hired the RQ *Serviços Aéreos Especializados* Ltd., which had the Airworthiness Certificate and the aircraft Annual Maintenance Inspection in regular situation, according to the ANAC"...

The air taxi service should be authorized and supervised by the ANAC and could only be provided by companies that met a series of requirements and demands that accredited them to provide the service in a legal and regular manner, in accordance with the RBAC 135.

1.18 Operational information.

On the day of the PT-HPG aircraft accident, the pilot arrived at the Campo de Marte Aerodrome, more precisely at the Marte Updates and Avionics Hangar, around 0945 (UTC), and went to prepare for the flight that would take place at 1100 (UTC).

According to observers, the pilot performed the pre-flight of the aircraft, passed the flight notification and called the fuel company.

At 1038 (UTC), fueling the aircraft started with JET A1 fuel, and at 1041 (UTC) fueling was completed. The total fuel supplied during refueling was 100 liters of aviation kerosene.

The total fuel capacity of the Bell 206B model aircraft was 291.7 liters (77.06 US Gallons), and the usable fuel was 287.7 liters (76 US Gallons) (Figure 72).

FUEL SYSTEM SERVICING

Total capacity: 77.06 U.S. gallons (291.7 litres)

Usable fuel: 76 U.S. gallons (287.7 liters)

Figure 72 - Bell 206B fuel load capacity, Rotorcraft Flight Manual - Revision B-55 - 06DEC2018.

It was found that the average fuel consumption of the Bell 206B aircraft was approximately of 100 liters per flight hour.

It was not possible to calculate the total amount of fuel that the aircraft had to perform the flights of 11FEB2019. However, no evidence was found that the available fuel was not sufficient to carry out the programmed routes.

Since the amount of fuel existing before refueling was unknown, it was not possible to calculate the weights, both at SBMT takeoff, as well as at the time of the accident. However, no evidence was found, such as excess of passengers or cargo, to indicate that the aircraft was overweight and not balanced at the time of the accident.

During the procedures that preceded the engine start (Engine Prestart Check), described in Section 2 of the Rotorcraft Flight Manual - Revision B-55 - 06DEC2018, it was necessary to accomplish several tasks and, among them, was to check the lights of the aircraft alarm panel lights, "Warning and Caution Lights - Test" (Figure 73).

DOT APPROVED 206B FLIGHT MANUAL Section 2 BHT-206B-FM-1 Warning and Caution lights — Test.

TOT LT TEST light (if installed) — Test.

Figure 73 - Extract from the Engine Prestart Check, Rotorcraft Flight Manual - Revision B-55 - 06DEC2018.

The tasks described in the Engine Prestart Check procedure were to be performed before all aircraft engine starts.

It is important to note that if any of the lights on the alarm panel (Warning and Caution Lights) were inoperative, the flight could not be performed.

The aircraft took off from SBMT at approximately 1120 (UTC) to the Bandeirantes Helipad (SDBH), São Paulo - SP, 6.8 NM away, and it landed at approximately 1128 (UTC).

At about 1147 (UTC), after the passenger boarded, the aircraft took off from SDBH to the Royal Palm Plaza Helipad (SSQW), Campinas - SP, 44.4 NM away, where it landed at around 1215 (UTC).

After the passenger disembarked, the pilot took off from SSQW to the Campos dos Amarais State Aerodrome - Prefeito Francisco Amaral (SDAM), Campinas - SP, at about 5 NM, where he landed at an Aerodrome square near a Maintenance Organization.

According to information from the shop staff, the pilot reported that there was a light on the aircraft panel, but he did not specify which.

The OM's owner questioned whether the pilot would want to carry out maintenance, in order to be able to open a Service Order, which he declined.

The owner of the OM also said that he had made the use of the hangar available for the maintenance to be carried out outside the headquarters by the WM *HELICÓPTEROS*, responsible for the last maintenance of the aircraft, if it was in the pilot's interest.

The pilot spent approximately 45 minutes on the ground and with the engine fairing open, while waiting for the time to return to SSQW. At no time was the SDAM airport operator informed of the landing by the aircraft pilot.

At 1340 (UTC), the aircraft landed on SSQW. The pilot disembarked, with the rotor spinning and boarded the passenger. At 1349 (UTC), the aircraft took off to SDBH.

Just before 1405 (UTC), the PT-HPG aircraft started to be recorded by a security camera from the Rodoanel Mário Covas concessionaire, CCR Rodoanel, SP-021 Highway, Km 7, on a downward trajectory.

A video analysis was performed, in order to obtain an estimate of the aircraft speed in horizontal displacement and, for this purpose; the aircraft length and video frames were used as a reference. Thus, the approximate speed obtained was of 60kt.

The profile observed in the recordings of the security camera, regarding the horizontal speed and sink rate was compatible with the autorotation maneuver.

The speeds with the lowest descent rate and maximum range of the aircraft in selfrotation, according to the Rotorcraft Flight Manual, were, respectively, 52kt and 69kt.

The autorotation procedure is required when the engine fails in flight (Figure 74).

ENGINE FAILURE AND AUTOROTATION
Collective pitch — Adjust, as required, to maintain rotor RPM, 90 to 107%.
NOTE
Rotor RPM maintained at the high end of the operating range will provide maximum rotor energy to accomplish the landing; but will cause an increased rate of descent.
WARNING
REDUCE FORWARD SPEED TO DESIRED AUTOROTATIVE AIRSPEED FOR EXISTING CONDITIONS. AIRSPEED FOR MINIMUM DESCENT IS 60 MPH (52 KNOTS) IAS. AIRSPEED FOR MAXIMUM GLIDE DISTANCE IS 80 MPH (69 KNOTS) IAS.

Figure 74 - Engine failure and autorotation, Rotorcraft Flight Manual - Revision B-55 - 06DEC2018.

Near the landing, making a profile compatible with the autorotation profile, the aircraft collided with a truck moving perpendicularly (Figure 75).

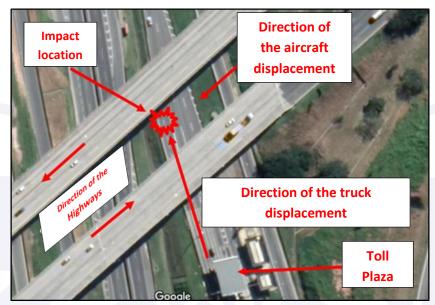


Figure 75 - Sketch of the occurrence site.

The analysis of the images did not suggest any problem of controllability of the helicopter during the whole recording.

The last two FAPs, related to the HMNT qualification revalidation exams, of the years 2016 and 2018, brought the information that he performed the autorotation procedure satisfactorily.

1.19 Additional information.

On 17APR2019, the ANAC launched https://sistemas.anac.gov.br/voeseguro/, using *VOE SEGURO* – Air Taxi, through apps for mobile devices or electronic address (Figure 76).

		Canac
onsulta de empresas e de aeronaves	de táxi-aéreo	
A ANAC disponibiliza uma consulta de empres Utilize esta consulta antes de contratar os serv Razão social ou CNPJ da empresa *	as ou aeronaves de táxi-aéreo a todos os cidadãos interessados. gos de uma empresa do ramo.	
Ou Marcas de nacionalidade e matricula da ar PXAAA	ronave: *	
Acesse do seu celular:		
	a. 0 ve ∎942 a.	
App Store	Google Play	
		C Limpar Q Pesquisar

Figure 76 - Visualization of the VOE SEGURO – Air Taxi consultation page, on the ANAC website.

The VOE SEGURO – Air Taxi was an initiative of the Agency to try to curb the practice of clandestine air taxi.

The ANAC recommended to the user that, before hiring a chartered air transport, consult if the company was authorized to offer the expected service and if the aircraft could be used for this purpose.

After researching the CENIPA website, , it was verified the existence of a Final Report 103/CENIPA/2013, which occurred with the PR-DJC aircraft on 30MAY2013, where a passenger was hit by the main rotor of the aircraft after the commander left the aircraft with the engine running.

Regarding the passenger boarding and disembarkation operation, the (RBHA) 91, in Section 91.102 (e), nº 2 and nº 3, valid at the time, established that:

(e) No pilot in command of an aircraft may allow passengers to board or disembark his aircraft with the aircraft engine(s) running, **unless** *:

(2) for a **helicopter** *, in addition to the applicable requirements of paragraph (f) (1) of this section, it is possible to stop the main rotor(s) or, if this is not possible, the engines are maintained idling and the height of the lower main rotor plane is sufficient to allow passengers to pass under it with a safety margin; and

(3) the pilot in command takes responsibility for the operation and takes appropriate **measures to ensure the safety of the operation** *.

(f) No pilot in command of an aircraft may allow his aircraft to be fueled with the engine(s) running (except APU's), unless the operation is conducted by the pilot in command in accordance with procedure established in the aircraft Flight Manual or in accordance with other procedures approved by the DAC. Additionally,

(1) there cannot be a passenger on board.

* our emphasis

In addition, Law nº 7,565, from 19DEC1986, the CBA, in its Chapter III (Of Infractions), Art. 302, item II, letter S, established that infractions are attributable to airmen or aircraft operators, leave the aircraft with the engine running without a crewmember on board.

1.20 Useful or effective investigation techniques.

Nil.

2. ANALYSIS.

It was a chartered flight, between the Bandeirantes Helipad (SDBH), São Paulo - SP, and the Royal Palm Plaza (SSQW), Campinas -SP, in round-trip legs, hired by the *Zum Brasil* Company, which operated in the Corporate Events Sector, to transport a passenger who would attend a pharmaceutical laboratory convention, in the city of Campinas.

Although it was not possible to confirm the fuel and weight information, there was no evidence that the fuel available on the aircraft was not sufficient to carry out the scheduled flights or that the weight and balance may have contributed in any way to the event in question.

However, the Operating Company did not have an operational authorization issued by the ANAC to carry out passengers transport, in the air taxi category, although it offered this service on its digital website. In 2011, the company had already been fined by the ANAC for offering services without proper certification.

Thus, the pilot was not qualified to perform passengers or cargo non-regular public air transportation in the air taxi category, since, for this, he should have undergone an operational training program approved by the ANAC, under the terms of the RBAC 135.

According to a press release, the company that hired the passenger transport service, even after the accident, believed that the Airworthiness Certificate and the Annual

Maintenance Inspection of the aircraft were enough to certify the operator's adherence to the standards, and the ability to provide the contracted service.

However, passengers transportation for a fee could only be carried out by companies certified by the ANAC for a specific purpose and that met a series of regulatory requirements that accredited them to provide the service in a legal and regular manner. The provision of the air taxi service by the RQ *Serviços Aéreos Especializados* Ltd. could not be performed and it characterized a violation of the current regulations issued by the ANAC.

Although it was reported by some interviewees that accepting work outside the company's EO was not the pilot's usual behavior, this had already occurred previously, as recorded in a notice issued by the regulatory agency.

People close to the pilot-owner reported that the acceptance of this charter might have occurred due to financial issues, as the company was in low demand for jobs at the time, flying about three and a half hours a month, which worried the pilot-owner.

This perception was reinforced by the behavior of the pilot-owner. It was reported that he worked on Saturdays, Sundays and holidays to cover financial obligations. He kept the office phone transferred to his cell phone on weekends, so as not to miss the opportunity to make new flights that might appear.

In this context, it is possible that the Company's financial situation has fostered, over time, the adoption of attitudes and practices that differed from the rules and procedures prevised for air operations carried out by the Company.

The flight started in SBMT with the initial transfer to SDBH, where the passenger was taken to the Royal Palm Plaza Helipad (SSQW), Campinas - SP.

After leaving the passenger at the destination, the helicopter was transferred to SDAM, where there was an OM. According to its owner, the pilot mentioned that there was a light on the aircraft panel, without specifying which light was that.

The owner of the shop claimed that he made normal protocol requirements to receive the aircraft, such as opening a Service Order, which resulted in the commander's refusal.

At 1340 (UTC) the aircraft returned to SSQW. The pilot disembarked, with the rotor working, with no one at the controls of the helicopter, and boarded the passenger. At 1349 (UTC), takeoff was made to SDBH.

Although it did not influence the accident in question, the abandonment of the cabin with the rotors working to assist the passenger, during boarding, characterized a non-compliance with the rules.

As for the flight back to SDBH, the analysis of the video from the Rodoanel concessionaire's security camera allowed the aircraft horizontal speed to be estimated at approximately of 60kt. This value was compatible with the procedure required for aircraft with engine failure in flight and was among the lowest descent and maximum reach speeds during the autorotation maneuver.

The images also made it possible to rule out the possibility of failures involving the controllability of the helicopter during the flight.

Analyzing the images of the field investigation and the sketch, the Investigation Team inferred that the aircraft approached the grassy space between the two elevated runways of the Rodoanel, and perpendicularly to the marginal lane of the Anhanguera Highway (Figures 31 and 32).

The pilot was unsuccessful in this approach and ended up overcoming the probable intended landing site, having no option but to try to land on the marginal lane of the Anhanguera Highway. Thus, it was found that there may have been an inadequacy in the use of the controls, which would have allowed the aircraft not to reach the chosen area during the autorotation, culminating with the attempt to land on the place where the accident occurred.

The commander of the aircraft died as a result of injuries caused by the collision of the aircraft against the truck. The dosage of carbon monoxide found in his body characterized carbonization as secondary, that is, post mortem.

Therefore, after analyzing the video images from the security camera, it was concluded that the flight profile was compatible with an autorotation and that hypotheses of failures that involved the helicopter's controllability during the flight were discarded, the research lines were directed to the powertrain.

Thus, when analyzing the connection shaft between the Gearbox and the tail rotor (Figure 34), it was noticed that it was sectioned. The examinations concluded that the rupture occurred due to overload.

The flexible blades had different aspects between the side referring to the tail rotor and the side referring to the freewheel exit (Figure 35), showing a possible locking of part of the shaft connected to the tail rotor and a continuous rotation of part of the shaft connected to the Gearbox and, consequently, the freewheel assembly.

The fracture morphology of the connecting shaft rupture without helical deformation on the connection side with the tail rotor and with deformation on the output side of the Gearbox indicated that it was rotating at the moment of the collision with the truck.

The rotation of the connecting shaft could indicate that the engine was working at the time of the collision or that, even with the engine inoperative, the freewheel system was maintaining the rotation of the shaft while the main rotor was spinning.

Since the aircraft was carrying out a flight profile that suggested the execution of an autorotation, it is possible that, with the engine inoperative, the freewheel was correctly transmitting the turn between the main and tail rotors. However, in the face of an unsuccessful forced landing, the tail rotor would have collided with obstacles, causing it to lock up before the main rotor stopped.

Such dynamics would explain the flexible blades present different aspects between the side referring to the tail rotor and the side referring to the freewheel exit and the morphology found in the section of the connection shaft between the engine Gearbox and the tail rotor.

The fuel system and its components showed no discrepancies or indications that it worked abnormally, which ruled out its contribution to stopping the engine.

The compressor section showed no signs of material ingestion. Likewise, the turbine section showed no mechanical damage or signs of having worked at abnormal temperatures. Its bearings, shafts, rotating blades and stator were shown to have a normal operating appearance, suggesting the absence of material ingestion by the compressor, eliminating the Foreign Object Damage (FOD) hypothesis.

The stator and rotor vanes of the axial compressor did not present any deformations.

A small loss of material was seen in the impeller of the centrifugal compressor in a small area in its diameter, not configuring ¼ of rotor rotation turn, in addition to a rubbing in the housing surrounding this compressor. This information allowed us to affirm that there was no rotation of the compressor shaft and that the engine had a mechanical lock before the moment of the collision with the truck.

The Gearbox, connected to the compressor section, showed thermal damage in its lower external part, probably due to the fire of the occurrence, which is confirmed by the state of the burnt oil residues (sludge) found inside (Figure 52), locking its components.

The Gear Box module was considered a maintenance item *on condition* (OC). The repair service on the Gear Box module by the ATC company, for which the SEGVOO 003 ATC 417/11 was issued, was considered the last record of maintenance intervention found in the available documentation.

During the separation between the compressor section and the Gearbox, bearing n^o 2 was found broken and locked, with the ball separator fractured in several parts, in addition to the balls showing abnormal wear and ovalization.

The bearing was a PMA component, with FAA approved design and production. However, it was not possible to identify, in the documentation obtained by the Investigation Team, when this item was installed and/or inspected on the SN CAC-30992F compressor.

Stereoscopic examinations showed wear and loss of material in the external and internal tracks of bearing n^o 2, probably due to having been subjected to work overload.

Once the failure of bearing nº 2 was identified, efforts were directed towards the lubrication system responsible for its oiling and cooling.

There was not enough oil in the lubrication system to collect and perform spectrometric analysis, due to the rupture of the lines.

Continuing the analysis of the lubrication system, no foreign material dirt / wreckage was observed when inspecting the oil pressure filter element, as well as in its housing.

The upper and lower Magnetic Chip Detectors, installed in the Gearbox, contained a significant amount of material, apparently ferrous, covered by an oily substance similar to gel.

The X-ray fluorescence analysis (XRF) performed on the collected residues at the active ends of the auto switches revealed that the composition of the collected residues was consistent with the material of a common bearing. The analysis also detected traces of silver, which were compatible with the material used to cover the bearing separators (Figure 51).

The continuity tests on the fillings magnetic detectors confirmed that the resistance of the space at its ends was significantly less than the value specified for a clean detector, indicating electrical continuity, that is, the circuit was closed. In this condition, the Eng Chip light indication on the cabin's Warning and Caution Lights should be on.

The tests carried out on the aircraft's Warning and Caution Lights panel lamps showed that the two lamps in the slot referring to the Eng Chip warning had broken filaments, presenting deformation compatible with use, not related to the impact. Thus, it was concluded that, even though the circuit was closed, the Eng Chip's warning was not ON at the alarm lights panel, at the moment of impact.

The Team noted that, before each start, the pilot was expected to check the operation of the Warning and Caution Lights alarm lights. If any lamp did not light up during the test, or even if any lamp remained ON after starting, there would be a need for corrective maintenance action.

As the aircraft was not equipped with flight recorders, it was not possible to verify whether the tasks described in the Rotorcraft Flight Manual, among which the task of checking the Warning and Caution Lights during the Engine Prestart Check, were performed by the pilot.

Thus, it was not possible to specify the condition of the Eng Chip light when the Engine Prestart Check was performed, before the SDAM took off, taking into account that it was carried out in accordance with the recommendations in the checklist.

Another element of the lubrication system, verified in detail, was the oil delivery tube, which was visually inspected and residues of foreign material were observed in the hole responsible for supplying oil for lubrication of bearing n^o 2 (Figure 53).

The low-pressure test and the examination performed using the scanning electron microscope confirmed the obstruction of the duct responsible for lubricating this item.

Inspection using TC, which assessed the extent of the blockage in the passage of the oil jet, allowed us to conclude that approximately half the length of the passage duct was blocked, preventing the correct functioning of the lubrication system.

Bearing nº 2 was not receiving lubricating oil from the plugged hole it was intended for, and possibly, it only received oil splashes from other lubrication points in the Gearbox.

The results observed in the examinations, tests and researches allowed to conclude that the obstruction of the orifice that directed oil to the bearing n° 2 resulted in a deficient lubrication and later fracture, due to overload, without indications of fatigue in the material.

It was possible to identify that the type of material present in the obstruction of the tube was basically composed of carbon.

Bearing n° 2 failed due to insufficient flow of cooling and lubricating oil. As a result of this failure, bearing n° 2 no longer axially positioned the compressor rotor, allowing contact between the impeller and the compressor housing. The contact of the rotating part with the static part caused a drag in the N1 system and a disruption in the engine airflow, leading to loss of power in flight.

During the investigation, it was not possible to locate and access all the maintenance records of the PT-HPG aircraft, being possible to consult only part of the information.

The airframe and engine logbooks analyzed were outdated (Part I). The last registration had been made in December 2018 (Figure 6).

So that the airframe and engine logbooks analyzed were updated, the last entry should have been made on 05FEB2019, in accordance with IS No. 43.9-003, Revision A, in force on the date of the accident.

The Airframe Logbook, 02 / PT-HPG / 03, had its opening term dated 15MAR2003 and its closing date on 01DEC2012 (Figures 7 and 8, respectively) and the Airframe Logbook n^o 05 / PT-HPG / 12 had its opening term dated on the same day as 02 / PT-HPG / 03. Although the entire documentation of the aircraft was not made available, it would not be possible to have logbooks 03 and 04; therefore, the numbering sequence is inconsistent.

In addition, there were signs of erasures on the inside pages of both logbooks, pages without identification and / or in disagreement with what was stated in the opening term.

Such information raised doubts about all maintenance records for the PT-HPG aircraft, leading to the need of consulting the records made available by the ANAC and by different OMs that performed services for the operator.

The consultation of the Log Cards allowed to identify that the compressor installed on the aircraft, SN CAC-30992F, had gone through Overhaul on 01JUL1988 (Figure 16).

On May 8 and 9, 2017, the aircraft was considered "non-airworthy" when submitted to the VTE carried out by the ANAC. Among the non-conformities reported in the RNC, the last line of item n^o 03 described that the 3,500-hour inspection of the SN CAC 30992F compressor was overdue.

According to the record contained in the Engine Log, Part IV - Controlled Components Installation and Removal Records, the SN CAC 30992F compressor was removed for the reason "Overhaul", as it had reached 3,510.1 hours TSO, and the SN CAC 31284 compressor it was installed with TSO 0.0h (Figure 22).

After replacing the compressor and proving the correction of the non-conformity, the ANAC released the aircraft on 09AUG2017.

However, seventy days after the aircraft was released by the ANAC, the SN CAC-30992F compressor set was re-installed on the PT-HPG aircraft engine, by the OM WM Helicópteros and it was recorded on page 120/151 of the Engine Logbook that the compressor would be with 373.3 hours TSO (Figure 23).

After the removal of the SN CAC 30992F compressor by the HBR Company, no record was found and / or presented that proves it had been submitted to another Overhaul after 01JUL1988.

Service Order No. 3408, issued by the maintenance organization WM Helicopters (Figure 24), also stated that the SN CAC-30992F compressor would be with 373.3 hours TSO. Attached to this OS, there was a copy of the record called Log Cards Part IV, page 3, which attempted to support the installation of the SN CAC-30992F compressor set on the engine and, consequently, its release for return to service of the aircraft on 18OCT2017 (Figure 25).

As described in the registration of this Log Card, presented by the WM Helicópteros, the OM ATC-Aeronaves Turbinas e Componentes Ltd., it would have performed the Overhaul on the SN compressor CAC-30992F on 08DEC2011 and, from that date on, its Overhaul time would start running again, that is, considering the manufacturer's maintenance program, it would have 3,500 hours until the next Overhaul.

Also in the Log Card Part IV, page n° 3 of the compressor set, in the Remarks area, it was indicated the Work Order (W / O) n° 24177 for details of the works performed.

When consulting the monthly report of services performed by the ATC Company (Figure 18), referring to December 2011, it was possible to identify that W / O 24177 referred to SEGVOO 003 ATC 414/11, which attested the return to service of the complete engine (SN CAE821758), while W / O 24179 referred to SEGVOO 003 ATC 417/11, and attested the return to service of the compressor module (SN CAC30992F), both after repair.

No record was found in the copies of SEGVOO 003 No. ATC 00414/2011 (Figure 26) and SEGVOO 003 No. ATC 00417/2011 (Figure 17), which mentioned any Overhaul service performed by the Aeronaves Turbinas e Componentes Ltd. Company, on the SN compressor CAC30992F.

The SN CAC30992F compressor module had undergone repair due to fillings and remained, after maintenance, with 3,136.8 hours TSO according to SEGVOO 003 No. ATC 00417/2011, dated 09DEC2011 (Figure 17).

The copy of the monthly report of services performed by the ATC Company, referring to December 2011, corroborated that the service performed by the maintenance organization was a repair completed on 09DEC2011, in the SN compressor module CAC30992F, documented by SEGVOO 003 ATC 417 / 11.

When consulting the entry and exit control of items (Figure 27), dated 09DEC2011, from the ATC Maintenance Organization, it was possible to observe that the SN compressor module CAC30992F entered and left the company with 3,136.8 hours of TSO.

Based on all information collected from the OM ATC-Aeronaves Turbinas e Componentes Ltd., it was possible to state that the SN CAC-30992F compressor module did not undergo Overhaul service in December 2011.

Thus, the reinstallation of the SN CAC-30992F compressor, without having passed through Overhaul, took the aircraft to the same "non-airworthy" condition found on May 8 and 9, 2017, during the VTE, carried out by the ANAC (Figure 21). In addition, it was also not possible to conclude the reason why it was attested that the SN CAC-30992F compressor had 373.3h TSO, in OS 3408 and in the Log Card Part IV, page n^o 3.

Considering that the ANAC attested, during VTE, that the aircraft was not airworthy using the SN CAC-30992F compressor, it was clear that the operator and the OM, which reinstalled the component, could not claim to be unaware of the need to perform the Overhaul.

In addition, according to the RR M250-C20 Operation and Maintenance Manual (OMM), engine oil changes should be carried out every 600 hours or 12 months, whichever comes first, but the maintenance records contained in the available Engine Logbook attested that the calendar interval for exchange was exceeded several times and for long periods of time.

This inadequate maintenance of the oil system possibly led to the formation of a sediment block in the channel from which the jet of oil supply to bearing n^o 2 would leave, which led to a condition of lack of lubrication, contributing to the failure of the engine in flight.

In turn, if the manufacturer's maintenance program had been carried out, bearing n° 2 would have been inspected and submitted to approval criteria when performing the overhaul of the SN CAC-30992F compressor module, according to manual M250-C20 Series Manual Overhaul, which would allow identifying the wear presented by bearing n° 2 and the deficiency verified in the lubrication system.

Thus, regardless of whether the pilot ignored the result of the lamp test or failed to do so, conducting the maintenance actions described above demonstrates that there was an attitude of non-observance of important procedures for the decision to fly safely.

In view of the scenario already exposed, it is possible that such an attitude was reinforced by the motivation that the pilot-owner would have in making the flight, considering the context of scarcity of jobs that his company was going through that year.

Thus, the financial relevance of this chartered flight for the company, at that moment, may have had an influence on the decision of the pilot-owner to assume it, even if he does not have authorization for this type of service, and compromised his ability to critically analyze the conditions in which he would operate it regarding safety.

In this scenario, the various aspects raised during the investigation revealed flaws in the organizational culture related to operational safety, from the sale of flights for which the company was not certified, to deficiencies in the maintenance processes.

Thus, the company, throughout its operation, adopted conducts that generated unacceptable risk conditions for the activity, showing vulnerabilities that contributed to the accident.

3. CONCLUSIONS.

3.1 Facts.

- a) the pilot had valid CMA;
- b) the pilot had valid HMNT Rating;
- c) the pilot was not qualified in that kind of flight (TPX Air Taxi);
- d) the RQ Serviços Aéreos Especializados Ltd. had operational authorization to operate a public air service specialized in aerial reporting, aerial photography and aerial cinematography activities;

- e) the RQ Serviços Aéreos Especializados Ltd. was not certified by the ANAC, according to RBAC 135, for paid passenger transportation (air taxi);
- f) the digital website of the RQ Serviços Aéreos Especializados Ltd. offered aerial photography, aerial filming, aerial reporting, air taxi, aerial searches, aerial inspections, weddings, panoramic flights, escorts, transportation of valuables and events;
- g) the Zum Brasil Company hired the RQ Serviços Aéreos Especializados Ltd. to transport a passenger between the Bandeirantes Helipad (SDBH), São Paulo SP, and the Royal Palm Plaza Helipad (SSQW), Campinas SP, in round-trip legs;
- h) the aircraft had a valid Airworthiness Certificate (CA);
- i) it was not possible to verify if the aircraft was within the weight and balance parameters;
- j) the airframe and engine logbooks records were outdated;
- k) the closing term for the Airframe Logbook No. 02 / PT-HPG / 03 and the opening term for the Airframe Logbook No. 05 / PT-HPG / 12 were dated 01DEC2017;
- I) there were erasures on the internal pages of Airframe Logbooks No. 02 / PT-HPG / 03 and 05 / PT-HPG / 12;
- m) it was not possible to specify the number of the Engine Logbook, due to the erasure in the identification of the number in the opening term. It was also observed that some pages were identified with the number 02, others with the number 03 and some without identification;
- n) it was not possible to locate and have access to all aircraft maintenance records;
- o) the weather conditions were favorable for the flight;
- p) the aircraft had flown 8 hours and 20 minutes after the last inspections performed on 06DEC2018;
- q) the aircraft was submitted to VTE, carried out by the ANAC, on 8 and 9 May, 2017;
- r) the aircraft was considered "non-airworthy" during VTE;
- s) the VTE Non-Conformity Summary described that the 3,500h inspection of the SN CAC 30992F compressor was overdue;
- the last Overhaul performed on the SN CAC 30992F compressor module was on 01JUL1988;
- u) the SN CAC-31284 compressor was installed in the engine and the ANAC released the aircraft on 09AUG2017;
- v) seventy days after the aircraft was released by the ANAC, the SN CAC-31284 compressor set was removed and the SN CAC-30992F compressor set was reinstalled;
- w) the M250 engine, which equipped the PT-HPG, allowed modular overhaul;
- x) the compressor module, SN CAC-30992F, underwent repair due to filings on 09DEC2011;
- y) in the entry and exit items control, from 09DEC2011, of the ATC company, the compressor module entered and left the company with 3,136.8 hours TSO;
- z) the record on page 120/151 of the Engine Logbook presented the information that the compressor, SN CAC-30992F, was running 373.3 hours TSO;

- aa) Service Order No. 3408, issued by the maintenance organization WM Helicópteros, presented the information that the compressor, SN CAC-30992F, was running 373.3 hours TSO;
- bb) attached to Service Order No. 3408, issued by the maintenance organization WM *Helicópteros*, there were copies of Log Cards;
- cc) according to the registration of Card Part IV, page nº 3, presented by the WM *Helicópteros*, the OM ATC-*Aeronaves Turbinas e Componentes* Ltd. would have performed an overhaul on the SN compressor CAC-30992F on 08DEC2011;
- dd) Card Part IV, page 3 of the compressor set, in the Remarks area, indicated Work Order (W / O) no. 24177 for details of the work performed;
- ee) W / O 24177 referred to SEGVOO 003 ATC 414/11;
- ff) SEGVOO 003 ATC 414/11 attested the return to full engine service after maintenance and did not refer to the overhaul of the compressor SN CAC-30992F;
- gg) SEGVOO 003 ATC 417/11 attested the return to service of the compressor module after repair and did not refer to the overhaul of the item;
- hh) the monthly report of services performed by the ATC Company, referring to December 2011, described the compressor module as REPAIRED in the "service performed" area;
- ii) no Overhaul record was presented or found on the SN CAC 30992F compressor module after 01JUL1988;
- jj) during the displacement of the aircraft between Helipads Royal Palm Plaza (SSQW), Campinas - SP, and Bandeirantes (SDBH), São Paulo - SP, an engine failure occurred in flight;
- kk) the displacement of the aircraft was recorded by security cameras on SP-021 Highway, Km 7;
- II) analysis of the cameras' footage allowed to discard hypotheses of failures that involved the controllability of the helicopter during the flight;
- mm) the estimated ahead speed of the aircraft was of 60kt;
- nn) the aircraft speed and descending profile were compatible with the autorotation procedure;
- oo) there was a flat area at the top of the Rodoanel runways, compatible for landing on autorotation;
- pp) the approach was made to the marginal lane of the Anhanguera Highway, between the two elevated lanes of the Rodoanel;
- qq) during the landing attempt, the aircraft collided with a truck moving perpendicularly;
- rr) the post-accident analysis concluded that the connection axis between the Gear Box and the tail rotor had rupture, due to overload applied to the material;
- ss) the flexible blades presented different aspects between the side referring to the tail rotor and the side referring to the free wheel exit;
- tt) the fractures found in the connection axis between the engine Gearbox and the tail rotor had different morphologies;
- uu) the connection axis between the Gearbox and the tail rotor was spinning at the time of the collision with the truck;
- vv) bearing nº 2 was locked and the ball separator fractured in several parts;

ww) the balls of bearing n° 2 showed abnormal wear and were oval;

- xx) the fracture of this bearing occurred due to overload without any signs of fatigue in the material;
- yy) bearing nº 2 failed due to insufficient flow of lubricating oil;
- zz) the oil delivery tube was half the length of the oil passage duct for bearing No. 2, which was blocked;
- aaa) the maintenance records contained in the Engine Logbook attest that the calendar interval for changing engine oil has been exceeded several times and for long periods of time;
- bbb) the M250 C20 Series Overhaul Manual provided that bearing nº 2 would be inspected and submitted to acceptance criteria during the Overhaul of the compressor module;
- ccc) the upper and lower magnetic particle detectors (Magnetic Chip Detectors) had a significant amount of ferrous material, covered by an oily substance similar to gel;
- ddd) the detectors' circuits were linked, that is, they were connected (electrical continuity);
- eee) the composition of the ferrous material collected in the Magnetic Chip Detectors was consistent with the material of bearing n° 2;
- fff) the two lamps referring to the Eng Chip indication had their filaments broken at the moment of impact;
- ggg) all lamps in the Warning and Caution Lights panel showed deformation compatible with use, with no evidence of hot deformation;
- hhh) the tasks described in the Engine Prestart Check procedure should be performed before all aircraft engine starts;
- iii) the Engine Prestart Check prevised the check of the Warning and Caution Lights warning lights;
- jjj) the aircraft could not take off if one of the lights was on, or if any of them were not operating;
- kkk) the aircraft was destroyed; and
- III) the occupant of the truck left unharmed and the occupants of the helicopter suffered fatal injuries.

3.2 Contributing factors.

- Control skills – undetermined.

There may have been an inadequacy in the use of the controls, which may have caused the aircraft not to reach the chosen area during the autorotation, culminating with the attempt to land on the place where the accident occurred.

- Attitude – a contributor.

The conduct, by the operator, of the maintenance actions demonstrated that there was an attitude of non-observance of important procedures for the decision to perform a flight safely.

In addition, the pilot disregarded the terms described in the RBAC 135 related to the air taxi mode, according to which he could not take this type of flight.

Organizational culture – a contributor.

The conduct presented at the company related to the use of the aircraft, as well as maintenance, reflected flaws in the organization's culture with regard to operational safety, since it was possible to observe a set of practices adopted that generated unacceptable risks for the execution of the activity.

- Flight indiscipline – a contributor.

The pilot-owner of the RQ *Serviços Aéreos Especializados* Ltd. performed a flight that went beyond the limits of the operator's authorization and for which he was not qualified.

In addition, the pilot-owner operated the aircraft with the TBO of the engine compressor module expired, which made it non-airworthy.

- Piloting judgment – a contributor.

There was an inadequate evaluation by the pilot of the parameters related to the operation of the aircraft during the execution of the autorotation and landing maneuver, which contributed to the outcome of the occurrence.

- Aircraft maintenance – a contributor.

The reinstallation of the compressor module with the expired TBO, as well as the subsequent release of the aircraft for return to service, showed inadequacy of the maintenance procedures performed by the OM.

Failure to comply with the maintenance program, particularly in relation to the calendar interval for changing the engine oil and reinstalling the compressor module with the expired TBO, demonstrated the non-adherence of the operator, who is primarily responsible for maintenance, in relation to the requirements of Continued Airworthiness, which contributed to this accident.

- Motivation – undetermined.

The financial return that the flight would bring to the company, in a time of shortage of contracted flights, may have motivated the pilot-owner to assume it, even though it was not certified for this.

- Decision-making process – a contributor.

The operational conditions in which the flight was performed, demonstrated that there was no critical analysis of the entire scenario involved, observing the possible risks and consequences inherent to the decision to execute it.

- Organizational processes – a contributor.

There was an inefficiency, both on the part of the operator and the maintenance organization, in monitoring and executing the maintenance processes.

The operator was aware of the fact that installing the compressor module without performing the overhaul, as well as exceeding the oil change intervals, contradicted the maintenance program provided for the aircraft engine, thus making it "not airworthy".

Likewise, the fact that the OM approved the return to service of the aircraft without proof of overhaul of the compressor module, contradicted the maintenance program prevised to the aircraft engine, since the helicopter would be "non-airworthy".

4. SAFETY RECOMMENDATION.

A proposal of an accident investigation authority based on information derived from an investigation, made with the intention of preventing accidents or incidents and which in no case has the purpose of creating a presumption of blame or liability for an accident or incident. In

addition to safety recommendations arising from accident and incident investigations, safety recommendations may result from diverse sources, including safety studies.

In consonance with the Law n°7565/1986, recommendations are made solely for the benefit of the air activity operational safety, and shall be treated as established in the NSCA 3-13 "Protocols for the Investigation of Civil Aviation Aeronautical Occurrences conducted by the Brazilian State".

Recommendations issued at the publication of this report:

To the Brazil's National Civil Aviation Agency (ANAC):

A-030/CENIPA/2019 - 01

Disseminate the lessons learned in this investigation, in order to alert pilots and operators of the Brazilian civil aviation about the consequences resulting from the non-compliance with the established in the Maintenance Programs of the manufacturers or approved by the Civil Aviation Authority.

A-030/CENIPA/2019 - 02

Disseminate the lessons learned in the present investigation, in order to alert the Maintenance Organizations about the consequences resulting from the non-compliance with the Maintenance Programs established by the manufacturers or approved by the Civil Aviation Authority.

A-030/CENIPA/2019 - 03

Work with the WM Helicópteros (COM nº 0304-05 / ANAC), in order to ensure that the maintenance services performed by it, occur in full compliance with the provisions of the Maintenance Programs prevised by the manufacturers or approved by the Civil Aviation Authority.

A-030/CENIPA/2019 - 04

Operate with the Civil Aviation System, aiming to prevent irregular conduct of non-regular public air transport in the air taxi mode.

5. CORRECTIVE OR PREVENTATIVE ACTION ALREADY TAKEN.

Although this accident was not the reason that triggered the action by the ANAC, on 17APR2019, it was launched, through apps for mobile devices or electronic address, https://sistemas.anac.gov.br/ voeseguro/, the VOE SEGURO - air taxi. This tool provides information about authorized companies and aircraft able to provide air taxi services.

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