



Statens haverikommission
Swedish Accident Investigation Board

ISSN 1400-5719

Report RL 2004:20e

**Accident involving helicopter SE-JUL
at the heliport at Linköping University Hospital,
Östergötland County, Sweden, on 5 June 2003**

Case L-19/03

SHK investigates accidents and incidents with regard to safety. The sole objective of the investigations is the prevention of similar occurrences in the future. It is not the purpose of this activity to apportion blame or liability.

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Translated by Tim Crosfield from the original Swedish at the request of the Swedish Accident Investigation Board.

In case of discrepancies between the English and the Swedish texts, the Swedish text is to be considered the authoritative version.

The report is also available on our web site: www.havkom.se

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2004-06-21

L-19/03

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Report RL 2004: 20e

The Swedish Accident Investigation Board (Statens haverikommission) has investigated an accident that occurred on 5 June 2003 at the heliport at Linköping University Hospital, Linköping, Östergötland County, Sweden, involving a helicopter with registration SE-JUL.

In accordance with section 14 of the Ordinance on the Investigation of Accidents (1990:717), the Board herewith submits a final report on the investigation.

The Board would be grateful to be informed, by 22 December 2004 at the latest, as to how the recommendations included in the report are being followed up.

An English summary of the report will be submitted in due course.

Carin Hellner

Mats Öfverstedt

Henrik Elinder

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L-19/03
Report finalised 21-06-2004

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| <i>Aircraft; registration and type</i> | SE-JUL, MBB BK 117B-2 |
| <i>Class, airworthiness</i> | Normal, valid Certificate of Airworthiness |
| <i>Owner/operator</i> | SOS Helikoptern Gotland AB/ c/o Forslund, Mickelsgårds, SE-621 72 Visby, Sweden |
| <i>Time of occurrence</i> | 2003-06-05, kl. 16.30 in daylight <i>Note.:</i> All times are given in Swedish summer time (UTC + 2 hours) |
| <i>Place</i> | Heliport, University Hospital, Linköping, Östergötland County, Sweden (pos. 582402N 153712E; 234 feet above sea level) |
| <i>Type of flight</i> | Commercial flight transport/Medical transport |
| <i>Weather</i> | According to SMHI analysis: gusty west wind 15-20 knots, good visibility, cloud 1/8 cumulus with base 4000 feet, temp./dew point +24/+12°C, QNH 1010 hPa |
| <i>Persons on board:</i> | |
| <i>crew members</i> | 4 |
| <i>passengers</i> | 1 |
| <i>Injuries to persons</i> | Considerable |
| <i>Damage to aircraft</i> | None |
| <i>Other damage</i> | None |
| <i>Pilot in command:</i> | |
| <i>Sex, age, licence</i> | Man, 39 yrs, BH-I |
| <i>Total flying time</i> | 8400 hours, of which 200 on type |
| <i>Flying hours previous 90 days</i> | 60 hours, of which 22 on this type |
| <i>Number of landings previous 90 days</i> | 22, of which all on the type |

The Swedish Accident Investigation Board (SHK) was notified on 1 July 2003 that an accident involving a helicopter with registration SE-JUL had occurred at the University Hospital heliport in Linköping, Östergötland County, Sweden, on 5 June at 16.30 hrs.

The accident was investigated by SHK represented by Carin Hellner, Chairman, Mats Öfverstedt, Chief investigator flight operations and Henrik Elinder, Chief technical investigator aviation.

The investigation was followed by Ragnar Boge for the Swedish Civil Aviation Administration .

Summary

The pilot performed an approach with his helicopter for landing on the University Hospital, Linköping, heliport. The landing was effected as a CAT A landing, which involves a relatively steep glide down to the touch down area. During the landing such powerful turbulence was generated that a woman walking outside the heliport area was knocked over and sustained a fractured hip.

SHK has found nothing to suggest otherwise than that the heliport area was arranged according to regulations in force and that the helicopter was being operated according to current regulations. The investigation showed that strong forces can arise and act upon people in the vicinity of a heliport in connection with takeoff and landing.

The accident was caused by the wind forces arising in the vicinity of the heliport in connection with the helicopter landing. A contributory cause was the fact that applicable systems of rules for the layout of helicopter heliport do not take account of the safety of persons and materiel in its proximity.

Recommendations

It is recommended that the Swedish Civil Aviation Administration, in consultation with the authorities affected, should publish information on the problem and supplement existing regulations for the layout and management of heliports in such ways that the safety of persons and materiel in their proximity is taken into account.

(RL 2004:20e R1).