REPORT TO THE ATTORNEY GENERAL
PUBLIC INQUIRY
THE FATALITY INQUIRIES ACT

CANADA
PROVINCE OF ALBERTA

WHEREAS a Public Inquiry was held at The Law Courts, Courtroom 448

in the City (City, Town, etc.) of Edmonton (Name of City, Town, etc.)

on the 18th day of November, 19 91 ~~and by adjournment~~

~~on the xxxxxxxxxxxxxxxxxxxxxx day of xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx 19xxxxx~~, before

Judge Guy E. Beaudry, a Provincial Court Judge.

A jury ☐ was ☒ was not summoned and an Inquiry was held into the death of

STEVE UNDERWOOD (Name in Full) 41 (Age)

of #2 Greenwood Place, Spruce Grove, Alberta (Residence) and the following findings were made:

Date and Time of Death August 18, 1990, approximately 9:15 a.m.

Place A field at Winterburn Road and 114 Avenue, Edmonton, Alberta

Medical Cause of Death (''cause of death'' means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization — The Fatality Inquiries Act, Section 1(d))

Multiple blunt injuries.

Manner of Death (''manner of death'' means the mode or method of death whether natural, homicidal, suicidal, accidental or undeterminable — The Fatality Inquiries Act, Section 1(g))

The manner of death was accidental.

CIRCUMSTANCES UNDER WHICH DEATH OCCURRED

The deceased, was one of four occupants of a Gazelle helicopter which crashed in an open field. It had lifted off from the Northland Heliport on a charter flight to Primrose Lake, Alberta. Shortly after take-off, the helicopter seemed to quickly disappear from sight. It is surmised that the pilot inadvertently flew into low clouds and became disoriented, and lost control of the helicopter. The pilot did not fully regain control before striking the ground, which occurred approximately two minutes after take-off. Evidence indicates that there was an attempt by the pilot to regain control but that the distance between the clouds and the ground did not allow him sufficient space and time to fully recover from the helicopter's dive. The helicopter was not equipped with instruments which would allow it to operate in clouds. At 9:00 a.m. the Municipal Airport in Edmonton was reporting a 400 foot ceiling and this was overcast status clouds. The International Airport was reporting 300 feet at the time. The basic minimum required for Visual Flight Rule (V.F.R.) was 1000 feet. There could have been a somewhat lower ceiling at the accident site, caused by higher ground elevation. This low ceiling was not apparent to the Heliport Manager who was on the ground at the time of take-off. She was surprised to see the helicopter disappear so quickly.

While fully qualified, the pilot had limited experience.

For all practical purposes, investigators at the scene and elsewhere (including a trip to the factory in France, where the helicopter originated) ruled out mechanical defects, which could have caused the crash. There was no evidence of pre-impact

failure of the helicopter.

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

The weather was an important factor in the accident. A proper weather report would have disclosed that morning that the conditions were unsuitable for helicopters using visual flight. Instrument meteorological conditions existed. While there is some evidence that the pilot obtained some kind of weather report before take-off, specific inquiries conducted shortly after this accident failed to reveal what information the pilot received as to the weather conditions prevailing at the time and from what source this information was obtained.

Consequently, it is recommended that helicopter pilots engaged in commercial operations be required to keep a log, noting before each lift-off a brief description of the weather report received and from what source, and that this written record be left with the Manager of Operations or left in the office or business premises, prior to the flight. This would encourage pilots to concentrate on the weather factor.

Secondly, having had the benefit of perusing the final report of the Transportation Safety Board of Canada, concerning this accident, which report has been publicly released, and having regards to the contents of this report, and considering the evidence which I heard, I would recommend further that Transport Canada prescribe that the flight time required for the issuance of a commercial helicopter pilot's licence be at least the equivalent to the minimum required for a commercial fixed wing airplane pilot's licence, which is 200 hours.

At page 2 of the Board's report on this accident, I quote as follows:

"The total flight time required for the issuance of a commercial helicopter pilot licence is 100 hours; whereas, the minimum required for a commercial airplane pilot licence is 200 hours. Helicopters are inherently more unstable than airplanes and require a greater skill level to master basic control. In addition, helicopters are used in more demanding environments, such a confined areas. The pilot had 112 hours when his commercial licence was issued, and 160 hours at the time of the accident."

Again at page 5:

"The pilot demonstrated to a Transport Canada flight test examiner that he had the required skill and knowledge to obtain a commercial helicopter pilot licence. Transport Canada issues commercial pilot licences for helicopters with half the experience required for that of an airplane licence.

DATED this 5th day of OCTOBER, 1992.

Judge G. E. Beaudry, A Judge of the Provincial Court of Alberta