

**AIRCRAFT ACCIDENT REPORT 1/2015**

**ACCIDENT INVESTIGATION DIVISION**

**Civil Aviation Department  
The Government of the  
Hong Kong Special Administrative Region**

**Report on the accident to Robinson R22 Beta II Helicopter  
Registration B-HJN operated by the  
Hong Kong Aviation Club Limited  
at Shek Kong Airfield, Yuen Long  
on 6 October 2013**

**Hong Kong  
February 2015**

In accordance with Annex 13 to the ICAO Convention on International Civil Aviation and the Hong Kong Civil Aviation (Investigation of Accidents) Regulations, the sole objective of this investigation is the prevention of aircraft accidents. It is not the purpose of this activity to apportion blame or liability.



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DEPARTMENT

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The Government of the Hong Kong Special Administrative Region

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5 March 2015

The Honourable C Y Leung, GBM, GBS, JP  
The Chief Executive  
Hong Kong Special Administrative Region  
People's Republic of China

Dear Sir,

In accordance with Regulation 10(6) of the Hong Kong Civil Aviation (Investigation of Accidents) Regulations, I have the honour to submit the report by Mr C M Hung, an Inspector of Accidents, on the circumstances of the accident to a Robinson R22 Beta II helicopter, registration B-HJN at Shek Kong Airfield, Yuen Long, on 6 October 2013.

Yours faithfully,

(Norman S M LO)  
Director-General of Civil Aviation

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## **GLOSSARY OF ABBREVIATIONS USED IN THE REPORT**

AIC	Aeronautical Information Circular
CAD	Civil Aviation Department Hong Kong
CFI	Chief Flying Instructor
CIA	Chief Inspector of Accidents
°	Degree
°C	Degree Celsius
DI	Duty Instructor
EAP	Emergency Action Plan
HKAC	Hong Kong Aviation Club Limited
kg	Kilogram
PPL	Private Pilot's Licence
SK	Shek Kong Airfield
UTC	Coordinated Universal Time
VFR	Visual Flight Rules
VHF	Very High Frequency

### **Notes :**

1. When abbreviations are used in this report, the full term is used in the first instance followed by the abbreviation in brackets.
2. All times in this Report are in Hong Kong Local Time, which is eight hours ahead of the Coordinated Universal Time (UTC).

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**ACCIDENT INVESTIGATION DIVISION**

**CIVIL AVIATION DEPARTMENT  
HONG KONG**

**Aircraft Accident Report 1/2015**

Registered Owner: Hong Kong Aviation Club Limited

Operator: Hong Kong Aviation Club Limited

Aircraft Type: Robinson R22 Beta II Helicopter

Nationality / Registration: B-HJN

Place of Accident: Shek Kong Airfield, Yuen Long  
New Territories, Hong Kong

Latitude: 22° 26.2' N

Longitude: 114° 04.8' E

Date and Time: 6 October 2013 at 15:55

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## **SYNOPSIS**

On 6 October 2013, a Robinson R22 Beta II helicopter, registration B-HJN of the Hong Kong Aviation Club Limited (“HKAC”), was on an instructional flight within Shek Kong Airfield (“SK”), with a flying instructor and a student pilot (“student”) on board. While the student was in control under the instruction and supervision of the flying instructor for a hover exercise, the helicopter drifted to the right and its right skid contacted the ground. The helicopter then rolled 90° to the right, hit the ground and came to rest on its side. The engine stopped on impact. The helicopter sustained substantial damage. Both occupants exited through the left door without assistance. The flying instructor was not injured. The student suffered some minor injuries. HKAC subsequently moved the wreckage to its hangar in SK.

Civil Aviation Department (“CAD”) was informed of the occurrence by HKAC on 7 October 2013. A team of CAD Inspectors of Accidents immediately proceeded to SK to conduct a site survey and inspect the helicopter. The Chief Inspector of Accidents (“CIA”) ordered an Inspector’s Investigation into the accident in accordance with the Hong Kong Civil Aviation (Investigation of Accidents) Regulations (Laws of Hong Kong, Chapter 448B). The fundamental purpose of this investigation is to determine the circumstances and causes of the accident with a view to the preservation of life and the avoidance of accident in future, it is not the purpose of this activity to apportion blame or liability.

The investigation concluded the cause of the accident was that the flying instructor was unable to regain the control of the helicopter in time to prevent a dynamic rollover from developing.

The investigation team has made three safety recommendations.

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# 1. FACTUAL INFORMATION

## 1.1 History of Flight

1.1.1 At 15:55, 6 October 2013, a Robinson R22 Beta II helicopter, registration B-HJN, of the Hong Kong Aviation Club Limited (“HKAC”) operated by a flying instructor (“Instructor”) for an instructional flight, rolled over and came to rest on its right side, in Shek Kong Airfield (“SK”).

1.1.2 On that day, the Instructor was assigned with five training flights scheduled between 08:30 and 18:00. The accident happened on the fourth flight, which was a training flight on hover exercise. The hover exercise was conducted within SK, at the hover training circle located south of the runway. (See Figure 1)

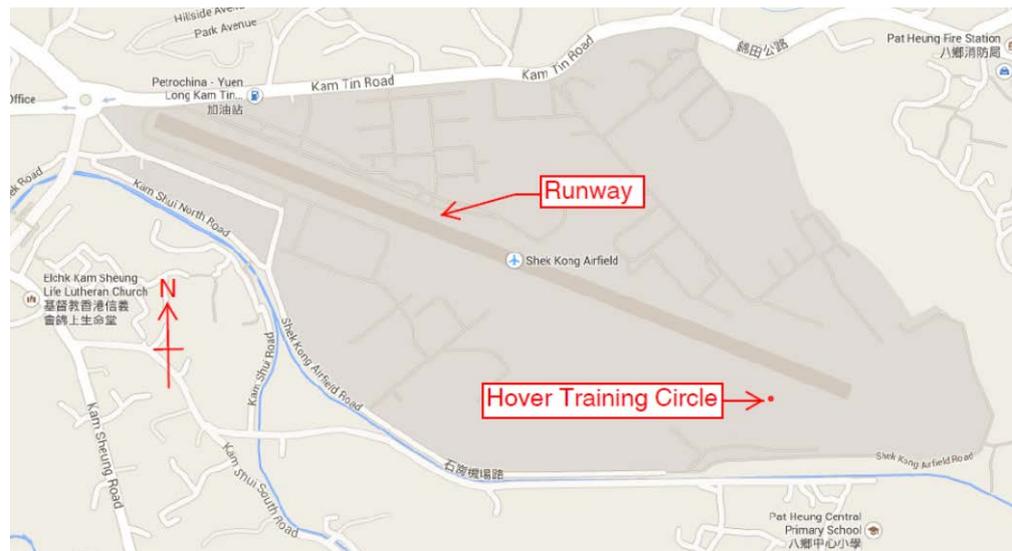


Figure 1 – The Hover Training Circle in Shek Kong Airfield

1.1.3 On completion of the pre-flight briefing and checks, the Instructor took off with a student pilot (“Student”) on board at about 15:35. The Instructor, on the left seat, operated the helicopter to the hover training circle. Having established the helicopter into wind over the circle, at a skid height (i.e. the height of the skid to the ground) of about four to five feet, the Instructor demonstrated to the Student the techniques of hovering.

1.1.4 As the exercise went on, the Student was progressively given the flying controls, namely the pedals, the collective and the cyclic to practise hovering under the supervision of the Instructor. The Instructor considered the progress of the Student was acceptable, thus he kept his hands and feet further away from the controls. At about eight minutes after the Student had been practising hovering with all three controls, with the skid height noted to be about three feet at that time, the helicopter drifted to the right rapidly.



Photograph 1 – The Wreckage

1.1.5 The Instructor described that he did notice the helicopter was drifting to the right. In a second, the drift developed rapidly into a descent and a roll. The Instructor attempted to reach for the controls but was not able to touch the controls in time. The right skid contacted the ground. The helicopter rolled over 90° to the right, hit the ground and came to rest on its side (See Photograph 1). The engine stopped on impact.

1.1.6 Both the Instructor and the Student were secured by the three-point seat harness assemblies. The Instructor turned off the master switch and the mixture. Both occupants exited the helicopter from the left door without assistance.

## **1.2 Injuries to Persons**

The Instructor was not injured. The Student suffered minor cuts as a result of the impact and was treated in the HKAC Flight Operations Room in SK.

## **1.3 Damage to Aircraft**

The helicopter sustained substantial damage.

## **1.4 Personnel Information**

### **Pilot (Instructor)**

Pilot	:	Male, aged 49 years
Licence	:	Private Pilot's Licence (Helicopters)
Type rating	:	Robinson R22, R44
Medical certificate	:	Class 2, renewed on 11 January 2013, valid until 31 January 2015. Limitations: Corrective lenses to be worn and additional spectacles to be available.
Flying Instructor's Rating Certificate of Test	:	10 December 2011, valid for 25 months
Certificate of Experience	:	22 June 2013, valid until 21 July 2014

Flying experience of the Instructor:

Total all types	:	1260 hours (fixed-wing and helicopter)
Total on Robinson R22	:	759 hours
Total on Robinson R22 as instructor	:	449 hours
Total on the day prior to the accident flight	:	3.1 hours
Total on the day before the time of the accident	:	3.6 hours

## **Student**

The Student was receiving his flying training for the Private Pilot's Licence ("PPL"). He had logged a total of 3.1 hours of flying under instruction on the Robinson R22. The accident flight was his first flight of the day.

## **1.5 Aircraft Information**

### **1.5.1 Aircraft**

Manufacturer:	Robinson Helicopter Company
Type:	R22 Beta II
Aircraft serial number:	2744
Year of manufacture:	1997
Certificate of Registration:	Issued on 1 June 2005 in the ownership of Hong Kong Aviation Club Limited
Certificate of Airworthiness:	Issued on 13 June 2013 in the Transport Category (Passenger) and valid until 12 June 2014
Engine:	One Lycoming O-360-J2A piston engine
Maximum Approved Gross Weight:	622.7 kg

Total airframe hours: 5218.9 hours

## **1.5.2 Airworthiness and Maintenance of Aircraft**

1.5.2.1 Aircraft technical record indicated that the helicopter had been maintained in accordance with the CAD approved maintenance schedule. The most recent scheduled checks were the 50-hour Inspection and 100-hour Inspection carried out on 4 October 2013. At the time of those inspections, the airframe and engine had each accumulated 5205.7 flight hours since new.

1.5.2.2 A review of the Aircraft Log Book revealed that the helicopter had no outstanding defects prior to the accident flight. The helicopter was fully serviceable in all respects.

## **1.6 Aircraft Description**

R22 Beta II is a single-engined helicopter manufactured in the United States. It is an entry-level two-seater helicopter and is equipped with dual controls. The primary structure of the fuselage is welded steel tubing and riveted aluminium. The tailcone is a monocoque structure in which the aluminium skins carry the primary loads. This helicopter is powered by a Lycoming O-360-J2A piston engine. Both the main and tail rotors have two all-metal blades.

## **1.7 Performance and Centre of Gravity**

The helicopter had been operating within its weight and centre of gravity limitations at the time of the accident.

## **1.8 Meteorological Information**

The weather conditions over Shek Kong were generally fine with wind from the northwest of around five knots. The temperature was around 31°C. The visibility was good.

## **1.9 Aids to Navigation**

The flight was conducted in day light under VFR. The helicopter was appropriately equipped with navigation instruments but they were not required for use in the accident flight.

## **1.10 Communications**

The helicopter was equipped with VHF radio which was serviceable.

## **1.11 Aerodrome Information**

The SK is located in Shek Kong, Yuen Long, New Territories, Hong Kong. It is a single runway airfield used by the People's Liberation Army (PLA). The HKAC has obtained the permission from PLA to use the airfield for general flying and flying training during weekends.

To operate within the airfield or the corresponding airspace, pilots are required to establish and maintain two-way communications on a designated radio frequency, to make "blind" radiotelephony transmission and to maintain listening watch for position reporting. The frequency also serves as a means of emergency alerting between aircraft and with the HKAC Flight Operations Room.

## **1.12 Wreckage and Impact Information**

Severe damage to the perspex canopy, horizontal stabiliser, main rotor blades, and deformation to the horizontal firewall were evident. The right skid tube extension was bent slightly inward. The damage was consistent with the impact upon the helicopter rolled over.

## **1.13 Fire**

There was no fire. Minor fuel spillage was found on the accident site.

## **1.14 Additional Information**

### **1.14.1 HKAC**

1.14.1.1 The HKAC provides facilities to enable members to obtain flying training, including PPL level in both fixed-wing aircraft and helicopters issued by the CAD.

1.14.1.2 The HKAC had 13 aircraft for general flying or flying training, including nine fixed-wing aeroplanes and four helicopters. Members might reserve and use these aircraft on a first-come-first-served basis. Booking of helicopters would be logged on the “Helicopter Booking” form. Five slots of 1.5 hour each from 08:30 to 16:00, and one two-hour slot from 16:00 to 18:00 may be scheduled for each helicopter on a day. All slots were back-to-back.

1.14.1.3 The Chief Flying Instructor (“CFI”) was responsible for all training and relevant activities in HKAC. Arrangements relating to aircraft booking and instructor assignment were facilitated by two HKAC full-time staff who were responsible to CFI on all matters relating to flying operations. The two staff neither had any flying experience nor had been given guidance in the scheduling of training slots taking into consideration of the instructors’ workload. The flying instructors were assigned to training flights primarily by matching their availability to the training demand. For helicopter flying training, the HKAC had four flying instructors.

1.14.1.4 The assignment of flying instructors was logged on the “Helicopter Booking” forms. No information on the details of the flying lessons other than the names of the flying instructor and the student on each flight were recorded.

### **1.14.2 Flying Training Arrangement and Execution**

1.14.2.1 The Instructor had, over a period of six months before the accident, commonly been assigned four to five training flights a day.

1.14.2.2 On the day of the accident, there were 12 helicopter training flights to be shared among three instructors. The Instructor and another flying instructor (“ ‘Instructor A’ ”) were each assigned five training flights starting at 08:30. The Instructor was assigned one flight between 08:30 and 10:00, and four flights between 11:30 and 18:00 (See Figure 2).

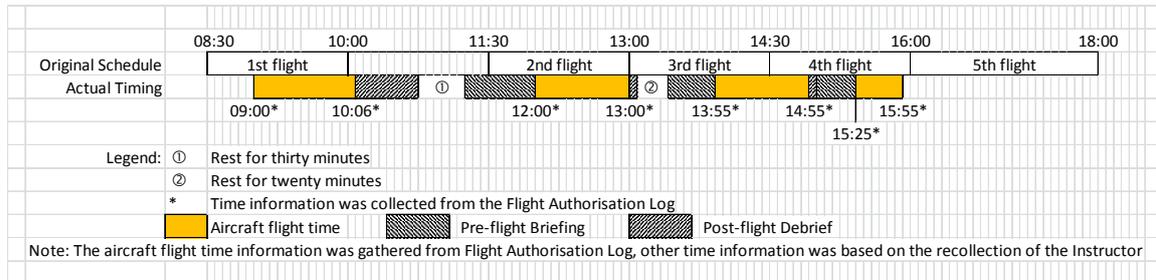


Figure 2 – Flying Training Arrangement and Execution of the Instructor

1.14.2.3 There were three different students scheduled for the second, the third and the fourth flight, all for hover exercises. The Instructor only became aware of this arrangement when reading the students’ training files in the morning. This was the first occasion that the Instructor conducted three consecutive training flights on hover exercises.

1.14.2.4 At about 09:00, the Instructor flew the first flight with a licensed pilot for an annual review flight. The flight finished at about 10:05. It was about 10:45 by the time the Instructor had finished the debriefing and the post-flight paperwork. He then rested for about thirty minutes and had some food for lunch.

1.14.2.5 The second flight was a continuation of the student’s hover exercise. The flight started at about 12:00 and lasted for about one hour. After the debriefing, the Instructor took a break for about 20 minutes. The third flight was an initial hover exercise, started at about 13:55 and finished at about 14:55. After the debriefing of the third flight, without a break, the Instructor started the pre-flight briefing at about 15:00 for the fourth flight that was again an initial hover exercise. The fourth flight was scheduled to commence at 14:30 but started at about 15:00.

### **1.14.3 Response to Emergency**

- 1.14.3.1 HKAC had an Emergency Action Plan (“EAP”). In case of any aircraft accidents and incidents, HKAC’s respective post holders would be required to take actions according to the EAP. A copy of the EAP was kept and accessible in the Flight Operations Room in SK.
- 1.14.3.2 In accordance with the Annex C (see Appendix A) of the EAP, depending on the seriousness of the occurrence, the CFI might submit a Mandatory Occurrence Report (“MOR”) or report the accident to CAD as per AIC 26/03: “Duty to report Aircraft Accidents”. The AIC 26/03 was enclosed in the HKAC EAP as Annex P.
- 1.14.3.3 The AIC promulgates the requirements of the Hong Kong Civil Aviation (Investigation of Accidents) Regulations regarding the reporting of aircraft accidents. When an accident occurred, the CIA should be notified as soon as possible, by the commander of the aircraft involved at the time of accident, or if he is killed or incapacitated, then the operator of the aircraft. To facilitate the report to be served, the AIC provides a telephone number that can be used on a 24-hour basis.
- 1.14.3.4 After the accident, the Instructor immediately informed the Duty Instructor (“DI”). The DI and the CFI arrived at the scene to assess what had happened about five minutes after the accident. ‘Instructor A’ subsequently arrived at the scene a moment later while the Chief Engineer of HKAC and his maintenance team followed shortly.
- 1.14.3.5 On the scene, none of the HKAC personnel declared that the occurrence had been an accident and thus activating the EAP accordingly.
- 1.14.3.6 The HKAC personnel recovered the helicopter to its upright position and moved it to the HKAC hangar in SK on 6 October 2013.
- 1.14.3.7 CFI informed CAD of the occurrence on 7 October 2013. The CIA ordered an investigation to be carried out in accordance with the Hong Kong Civil Aviation (Investigation of Accidents) Regulations.

## **2. ANALYSIS**

There were no videos, flight records nor ground witnesses of this accident. The Instructor and the Student were interviewed by the investigators three days after the accident. Relevant HKAC members and staff as determined by the investigation team were also interviewed or provided statements during the course of investigation. The analysis of the circumstances and causes leading to the accident was based on the information collected from interviews, statements, examination of wreckage and research.

### **2.1 Flight Operations**

#### **2.1.1 Dynamic Rollover**

2.1.1.1 Dynamic rollover begins when a helicopter starts to pivot around its landing gear with a lateral movement. It would happen when a helicopter is drifting sideways and yet its landing gear suddenly makes contact with the ground. Once the helicopter has started rolling to one side, simply applying opposite cyclic control alone would not be sufficient to arrest the rolling momentum. When the helicopter reaches a critical rollover angle, recovery is not possible.

2.1.1.2 A student, while operating a helicopter under the supervision of a flying instructor, may deviate from the normal attitudes. It is the judgement of the flying instructor to decide when to intervene and regain the control of the helicopter. At the time of the accident, the Student had been practising hovering with all three controls for about eight minutes. The Instructor described that the Student's progress was acceptable. Obviously, he had confidence in the Student and put his hands and feet further away from the controls.

2.1.1.3 The Instructor recalled that the helicopter was drifting to the right rapidly just a moment before the helicopter rolled over. Having noticed the drift, the Instructor considered that he should take control of the helicopter. He attempted to reach for the controls but could not do so in time. The drift quickly developed into a descent and a roll. This unchecked movement eventually caused a dynamic rollover.

2.1.1.4 The post-accident inspection noted an inward bend to the right skid tube extension of the helicopter. It indicated that the helicopter had the right skid tube extension contacted the ground during its rightward drift before the helicopter rolled over.

## **2.1.2 Workload of the Instructor**

2.1.2.1 Hovering is a demanding exercise for both flying instructor and student. It requires highly-coordinated motor skills to simultaneously handle all three controls, the cyclic, the collective and the pedals to keep an inherently unstable helicopter steady over a chosen datum. Any control inputs would normally have effects on the others. At the very beginning in learning hovering, students would normally have greater difficulty in appreciating the 'feel' in handling all three controls simultaneously. As such, while instructing hovering, the flying instructor has to be highly alert, monitoring the attitude of the helicopter, anticipating and correcting the control inputs of the student at all times.

2.1.2.2 Hover exercise is conducted close to the ground. Practising hovering of R22 helicopters would normally be conducted at a skid height not less than four feet above the ground. To train students on hovering, the flying instructor has to provide them with sufficient margin of tolerance. This would inevitably allow the helicopter to be at a skid height that is lower than four feet but within the margin of tolerance given to the student. Therefore, to maintain a safe operation, the flying instructor has to be continuously and critically judging the student's handling, the helicopter's attitudes and the need to regain the control of the helicopter. The flying instructor would have to maintain a high level of vigilance at all times throughout the exercise.

2.1.2.3 Considering the experience of the Instructor, he should be able to deal with the hover exercises under normal circumstance. However, on the day of the accident, the Instructor was scheduled consecutive hover exercises with three different students. Although the Instructor had the discretion in varying the execution of the training, he conducted the training as scheduled. It was the first time he had attempted to teach three consecutive hover exercises.

- 2.1.2.4 The workload of conducting consecutive hover exercises was high. It appeared that the rest prior to the second flight helped prepare the Instructor for the demanding workload, and the rest before the third flight might also help relieve the stress of the Instructor. The second and the third flight were conducted uneventfully.
- 2.1.2.5 At the post accident interview with the Instructor, he admitted that his alertness was slightly on the low side and could have been suffered from tiredness at the time of the accident.
- 2.1.2.6 Considering the high workload that the Instructor had experienced prior to the accident, he could have suffered from certain level of tiredness, thus affecting his judgement and alertness, during the accident flight.

### **2.1.3 Flying Training Arrangements**

- 2.1.3.1 The day-to-day flying training arrangement was administered by two full-time staff members. The two staff neither had any flying experience nor had been given guidance in the scheduling of training slots taking into consideration of the instructors' workload. Without considering the demand of each flying lesson, the training flights were assigned to the available flying instructors in a random manner.
- 2.1.3.2 The demand for helicopter flying training was high. It was common for a flying instructor to conduct four to five training flights a day, as was the case on the day of the accident. The arrangement was made primarily based on the training demand.
- 2.1.3.3 The back-to-back arrangement of the booking slots, in the context of flying training arrangement, provided little allowance for flying instructors to take rest between flights. Inevitably, pressure on flying instructors to work continuously would be high in particular when there was a need to catch up with the schedule.
- 2.1.3.4 Taking into account the high training demand, the practice of assigning flying instructors without due consideration to their workload and rest periods was conducive to the development of tiredness.

## **2.2 Emergency Response**

The occurrence was not considered as an aircraft accident by all HKAC personnel on the scene. As a result, the EAP was not activated and the wreckage was removed without notifying CAD.

## **2.3 Aircraft Airworthiness and Maintenance**

After examination of the wreckage, it was found that no pre-existing mechanical defect associated with the airframe and engine could have potentially contributed to the accident.

### **3. CONCLUSIONS**

#### **3.1 Findings**

- 3.1.1 The Instructor held a Private Pilot's Licence (Helicopters) with a Robinson R22 aircraft rating and a valid Class 2 Medical Certificate.
- 3.1.2 The helicopter had no defects prior to the accident flight and was fully serviceable in all respects.
- 3.1.3 The helicopter was operated within its weight and centre of gravity limitations.
- 3.1.4 The flight was conducted in day light under VFR.
- 3.1.5 The flying programme was tightly scheduled.
- 3.1.6 The accident flight commenced behind the schedule.
- 3.1.7 The Instructor had not taken a break immediately before the accident flight and had conducted three consecutive high workload flying lessons, i.e. the hover exercises, before the accident. He might have suffered from certain level of tiredness, which affected his judgement and alertness.
- 3.1.8 The Instructor could not regain the control of the helicopter from the Student in time.
- 3.1.9 A dynamic rollover happened to the helicopter.
- 3.1.10 The EAP of the HKAC had not been activated.

## **3.2 Cause**

The Instructor could not regain control of the helicopter from the Student in time before the dynamic rollover developed. (Refer 2.1.1)

## **3.3 Contributing Factors**

3.3.1 It was probable that the Instructor might have suffered from tiredness, which affected his judgement and alertness during the accident flight. (Refer 2.1.2)

3.3.2 The flying programme was tightly scheduled without considering the workload and rest periods of flying instructors. (Refer 2.1.3)

## **4 SAFETY RECOMMENDATIONS**

### **4.1 Safety Actions Already Implemented**

4.1.1 After the accident, HKAC suspended all flight operations at SK and conducted a review on its operations policies and procedures, flying orders and instructions, operation control, training programme and training standards. During the investigation period, HKAC had completed the review and issued new guidelines to Flight Operations and the flying instructors consisting of the following:

- (a) A maximum of four instructional flights be conducted by an instructor per day.
- (b) Instructors might not conduct more than two consecutive instructional flights without rest.
- (c) Consideration on separating “high stress” flights in flight programming.

4.1.2 With regard to emergency response, HKAC had revised their EAP to strengthen the following:

(a) Reportable Accident

The definition of “reportable accident” stated in the Hong Kong Civil Aviation (Investigation of Accidents) Regulations (Laws of Hong Kong, Chapter 448B) was reproduced in the EAP.

(b) Responsible Person

The new list stipulated the order of the responsible persons in giving notice of a reportable accident.

(c) Removal of Damaged Aircraft

Regulation 7 of the Hong Kong Civil Aviation (Investigation of Accidents) Regulations (Laws of Hong Kong, Chapter 448B)

was reproduced in the EAP.

## **4.2 Safety Recommendations**

### 4.2.1 Recommendation 2015-1

HKAC should review the control procedures to eliminate circumstances that can cause tiredness to flying instructors in instructional flying activities.

### 4.2.2 Recommendation 2015-2

HKAC should further enhance the understanding of its flying members, in particular its management and flying instructors, on the causes and effects of tiredness.

### 4.2.3 Recommendation 2015-3

HKAC should enhance the understanding of its management and flying instructors on the requirements of the Hong Kong Civil Aviation (Investigation of Accidents) Regulations (Laws of Hong Kong, Chapter 448B).

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ANNEX C

**HONG KONG AVIATION CLUB**  
**RESPONSIBLE PERSON AT SHEK KONG**

In order to provide an adequate emergency action plan at HKAC – Shek Kong, the following action must be accomplished at all times.

In the event of a Fixed Wing / Helicopter accident or incident at HKAC- Shek Kong, the responsible person shall activate the **EMERGENCY ACTION PLAN** as shown on **ANNEX D**.

**The responsible Persons for this Emergency Action Plan are as follows: -**

1. The Chief flying Instructor (CFI)/Acting Chief Flying Instructor (ACFI).
2. The Deputy Flying Instructor (DCFI), if CFI, ACFI is unavailable at the time of the accident or incident.
3. The Duty Instructor (DI) if CFI, ACFI, DCFI are unavailable at the time of the accident or incident.
4. The Duty Pilot (DP) if CFI, ACFI, DCFI, DI are unavailable at the time of the accident or incident.
5. The Flight Operations Assistant (FOA) if CFI, ACFI, DCFI, DI, DP are unavailable at the time of the accident or incident.

The above nominations shall provide adequate coverage at HKAC should an Emergency occur at all operation times within HKAC.

**Briefing of responsible persons for the Emergency Action Plan**

The CFI/ACFI HKAC shall brief the responsible person for the Emergency Action Plan.

A laminated copy is to be placed at Flight Operations Room. All responsible persons are to read the emergency action plan and get acquainted.

**Reporting of Incident / Accident**

- 1) Except the president of HKAC or CFI or General Manager, No other person shall release any information to the press.
- 2) Depending on the seriousness of the occurrence CFI may submit a MOR or report the accident to CAD as per HK AIC 26/03.

John Li  
Acting CFI  
22 February 2009

NB: Annex C dated 29 October 2007 has been superceded.

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