Continuing Airworthiness Notice – 27-014 Revision 2

MD Helicopters 369 series, 500N and 600N fitted with Pilot to Co-pilot Tail Rotor Torque Tube P/N 369H7531-XX

10 February 2020

Issued by the Civil Aviation Authority of New Zealand in the interests of aviation safety. A Continuing Airworthiness Notice (CAN) is intended to alert, educate, and make recommendations to the aviation community. A CAN contains non-regulatory information and guidance that does not meet the criteria for an Airworthiness Directive (AD). The inspections and practices described in this CAN must still be carried out in accordance with the applicable NZCAR Parts 21, 43 and 91 - CAN numbering is by ATA Chapter followed by a sequential number for the next CAN in that ATA Chapter.

Applicability:

MD Helicopters 369 series, 500N and 600N fitted with a Pilot to Co-pilot Tail Rotor Torque Tube P/N 369H7531-9, or -11, or -13.

Note 1:

CAN 27-014 revision 2, introduces MD Helicopters SB369H-263, SB369E-129, SB500N-066, SB369D-229, SB369F-119 and SB600N-080, dated 30 January 2020 (all contained in one document). This SB provides inspection instructions to determine the condition of the pilot to co-pilot tail rotor torque tube installed on affected helicopters.

Purpose:

This Continuing Airworthiness Notice (CAN) is issued to bring attention to a defect reported to the CAA of finding a severely cracked pilot to co-pilot tail rotor torque tube with P/N 369H7531-11 on a Hughes 369FF (MD530F) helicopter.

The investigation revealed that the crack initiated from the hole of the control rod fitting (bell crank/push-rod attachment bracket). For further detail refer to the photo on page 2 below.

Background:

This CAN is prompted by a defect reported to the CAA of finding a significant crack in the pilot to co-pilot tail rotor torque tube on a MD530FF helicopter. The defect resulted in a significant increase in LH pedal movement to the extent that the pedal was contacting the pedal stop. With full LH pedal applied the pilot could only just maintain heading and continue to a safe landing.

MD helicopters has advised of a similar overseas occurrence and they have now issued a service bulletin with instructions to inspect the pilot to co-pilot tail rotor torque tube on affected helicopters.

Recommendation:

The CAA strongly recommends compliance with the instructions in MD Helicopters SB369H-263, SB369E-129, SB500N-066, SB369D-229, SB369F-119 and SB600N-080 (all contained in one document), dated 30 January 2020.

Note 2:

If any defects are found in the pilot to co-pilot tail rotor torque tube, complete a CA005 Defect Report form and submit the completed form to the CAA at CA005@caa.govt.nz or report findings via the online reporting system available at https://occurrences.caa.govt.nz/ProdUI/

Please include all findings and any other relevant technical information. A CA005D Defect Report form can be obtained from https://www.aviation.govt.nz/about-us/forms/Filter/?SearchTerm=&Rule=8

This CAN is considered to be an interim action and further CAA action may follow.

Refer to the photo on page 2 for further detail of the location of the crack found in Pilot to Co-pilot Tail Rotor Torque Tube P/N 369H7531-11.

Location of the crack found in Pilot to Co-pilot Tail Rotor Torque Tube P/N 369H7531-11.