Aviation Safety Investigation Report 198800735

Schempp Hirth Discus B

15 October 1988

Readers are advised that the Australian Transport Safety Bureau investigates for the sole purpose of enhancing transport safety. Consequently, Bureau reports are confined to matters of safety significance and may be misleading if used for any other purposes.

Investigations commenced on or before 30 June 2003, including the publication of reports as a result of those investigations, are authorised by the CEO of the Bureau in accordance with Part 2A of the Air Navigation Act 1920.

Investigations commenced after 1 July 2003, including the publication of reports as a result of those investigations, are authorised by the CEO of the Bureau in accordance with the Transport Safety Investigation Act 2003 (TSI Act). Reports released under the TSI Act are not admissible as evidence in any civil or criminal proceedings.

NOTE: All air safety occurrences reported to the ATSB are categorised and recorded. For a detailed explanation on Category definitions please refer to the ATSB website at www.atsb.gov.au.

This accident was not subject to an on site investigation.

Occurrence Number: 198800735 **Occurrence Type:** Accident
Location: Gawler SA
Date: 15 October 1988 **Time:** 1640
Highest Injury Level: Nil
Injuries:

	Fatal	Serious	Minor	None
Crew	0	0	1	1
Ground	0	0	0	-
Passenger	0	0	0	0
Total	**0**	**0**	**0**	**1**

Aircraft Details: Schempp Hirth Discus B
Registration: VH-IUN
Serial Number: N/K
Operation Type: Private (Gliding)
Damage Level: Substantial
Departure Point: Gawler SA
Departure Time: 1612
Destination: Gawler SA

Approved for Release: 27 June 1989

Circumstances:

The pilot completed his pre-takeoff checks before launching for a local flight. He subsequently advised that while he was manoeuvring behind a glider ahead of him in the circuit the canopy rattled and flew open. He was unable to close the canopy and shortly afterwards it tore free from the glider structure. A successful and uneventful landing was then carried out. Investigation revealed that it was possible to close the canopy locking handle fully without the locking pins engaging in the lock studs. In this type of glider the unsecured canopy was then not easy to detect from inside the cockpit. The pilot had limited experience on type and was not aware of the difficulty in detecting an unsecured canopy. Physical checks for canopy security by pushing on the canopy were discouraged by the gliding club for fear of damage. The launching crew had not noticed that the canopy was unlocked during the hookup procedures.

Significant Factors:

The following factors were considered relevant to the development of the accident

1. The pilot had limited experience on the aircraft type.

2. The pilot did not ensure that the canopy was locked prior to flight.

3. The gliding club did not have adequate procedures in place to prevent this type of occurrence.