Aviation Safety Investigation Report 198900833

Piper Cherokee PA32

6 October 1989

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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.

Occurrence Number: 198900833 **Occurrence Type:** Accident
Location: American River South SA
Date: 6 October 1989 **Time:** 1647
Highest Injury Level: Minor
Injuries:

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

Aircraft Details: Piper Cherokee PA32
Registration: VH-WSZ
Serial Number: 32-7440026
Operation Type: Private
Damage Level: Substantial
Departure Point: Penneshaw SA
Departure Time: 1640
Destination: American River South SA

Approved for Release: 5th April 1991

Circumstances:

The Authorised Landing Area (ALA) at which the accident happened was the home field of the pilot. The ALA comprised two crossed grass runways the longer of which was judged by the pilot to be too bumpy for continued operations. On one end of the shorter runway there was a row of roadside trees. The pilot was in the habit of landing well into the shorter strip towards the trees and reportedly had no problems conducting safe landings. At the time of the accident the wind was reported as being calm and another aircraft was parked on the end of the runway near the trees. On landing the pilot touched down near her usual touchdown point but then felt the aircraft was not decelerating. Aware that there was an aircraft parked at the end of the runway the pilot became concerned that she might not complete the landing safely and initiated a go-around. In attempting to avoid the trees at the end of the runway the aircraft was banked to the left. However the left wing struck a steel cattle yard and was torn off. The aircraft then crashed through the trees and came to rest in scrub on the other side of the road. Investigation on site showed that the pilot had touched down some 200 metres into the strip and had probably accepted a higher threshold speed than that recommended in the performance charts. In addition the pilot had neither calculated the landing distance required nor measured the landing distance available. Consequently she was not aware of the consequences of exceeding the parameters specified in the landing performance charts or the magnitude of the distance penalty that would accrue from such excursions. Post-accident calculations showed that there was sufficient runway length available for a safe landing to be achieved. At the point in the landing roll at which the pilot attempted a go-around a successful takeoff could not be achieved within the runway distance remaining before the row of trees. There was much discussion generated during the analysis of the landing distance available and the use of the performance charts. It was discovered that Civil Aviation Authority (CAA) document AGA 6 is misleading and the CAA have already undertaken to review it to provide better guidance for pilots. This situation

was not judged as a causal factor in this accident as the pilot did not consult the subject reference or the performance charts. 3-

Significant Factors:

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

1. The pilot did not consult the performance charts for her intended operation.

2. The pilot was complacent about her aircraft operations.

3. The pilot delayed the decision to carry out a go-around.

Reccomendations:

Recommendations concerning the amendment of AGA 6 have already been made to and actioned by the Civil Aviation Authority.