

**Aviation Safety Investigation Report
198803486**

Beech 95-B55 Baron

2 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.

Occurrence Number: 198803486 **Occurrence Type:** Accident
Location: Kumbia (83 km NNW of Oakey) QLD
Date: 2 October 1988 **Time:** 1205
Highest Injury Level: Nil
Injuries:

	Fatal	Serious	Minor	None
Crew	0	0	1	1
Ground	0	0	0	-
Passenger	0	0	0	2
Total	0	0	0	3

Aircraft Details: Beech 95-B55 Baron
Registration: VH-AJM
Serial Number: TC-1061
Operation Type: Charter (Passenger)
Damage Level: Substantial
Departure Point: Roma QLD
Departure Time: 1112
Destination: Kumbia QLD

Approved for Release: 6 February 1989

Circumstances:

The company was tasked to operate into a strip adjoining a local race course. Details of the strip were obtained from a local pilot, who told a company pilot that there was a powerline at the eastern threshold of the strip. This pilot subsequently gave the strip data to the pilot who flew the aircraft. Upon arrival overhead the strip, the pilot saw powerlines off the western end and thought that these were the lines mentioned in the briefing. He then decided to land into the west. On late final approach, he saw the powerlines over the threshold and flew the aircraft under them. The resultant high rate of descent could not be arrested before ground impact and the aircraft struck the ground in a nose low attitude with the nosegear and propellers. The landing gear and propellers were torn off and the aircraft slid for 112 metres before coming to rest. The cabin was protected from high deceleration forces by the collapsing landing gear and the occupants escaped without injury. It was determined that the strip was not suitable in length or width for the operation of this aircraft type, and the briefing obtained on the strip was not adequate to determine the suitability of the strip.

Significant Factors:

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

1. The briefing obtained was inadequate to determine the suitability of the strip for the operation to be undertaken.
2. The strip was unsuitable for the aircraft type used.
3. The aerial inspection of strip performed by the pilot was inadequate.
4. The pilot elected to fly beneath the powerlines, and was unable to arrest the resulting high rate of descent.

Reccomendations:

It is recommended that the Civil Aviation Authority gives consideration to developing a standard proforma for the use of persons seeking information on the characteristics of Authorised Landing Areas.