

**Aviation Safety Investigation Report
198801413**

Aviasud "Sirocco"

6 March 1988

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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: 198801413 **Occurrence Type:** Accident
Location: 2.5 km south-west of Whittlesea VIC
Date: 6 March 1988 **Time:** 1525
Highest Injury Level: Fatal
Injuries:

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

Aircraft Details: Aviasud "Sirocco"
Registration: N/A
Serial Number: N/A
Operation Type: Private (Sport Aviation)
Damage Level: Destroyed
Departure Point: Whittlesea VIC
Departure Time: 1510
Destination: Whittlesea VIC

Approved for Release: 24 October 1988

Circumstances:

According to his log book, the pilot had flown the aircraft on two previous occasions of about 15 minutes duration each. The pilot was briefed by the owner of the aircraft on power settings and speeds. He then took-off into the south from the strip which is aligned approximately north-south. There was a light southerly breeze blowing at the time. The aircraft was seen to make one right-hand circuit, but it could not be determined if the aircraft actually made a landing from that circuit. When the aircraft was on final approach from a second right-hand circuit at an estimated altitude of about 200-300 feet, it entered a turn to the right. As the turn progressed onto a northerly (downwind) heading, the angle of bank became progressively steeper until it was about 90 degrees. The nose then dropped and the aircraft dived to the ground. The first persons on the accident scene experienced difficulty in removing the pilot's motor cycle type safety helmet (with full face enclosure) before resuscitation could be applied. The investigation did not reveal any pre-existing defects that may have caused the accident. Other pilots reported some turbulence and windshear in the area where the accident occurred. The area was inspected by an officer from the Bureau of Meteorology who specialised in micro-meteorology. His opinion was that turbulence or windshear effects at the time of the accident would have been minimal. The pilot had been receiving dual flight instruction from an ultralight flying school. After a dual instructional flight on the morning of the accident, he had been strongly advised by his instructor not to fly solo until he had completed more dual instruction as the instructor believed that the pilot was not sufficiently competent to fly solo. The pilot lost control of the aircraft for reasons which were not determined.

Significant Factors:

It was considered that the following factors were relevant to the development of the accident

1. The pilot was participating in a deregulated area of aviation, and was not required to achieve or maintain any particular level of flying ability.
2. He had very little theoretical or practical knowledge of flying.
3. The pilot had been advised not to fly solo because he was considered unsafe for solo flight, but this advice was ignored.

Reccomendations:

1. It is recommended that the Australian Ultralight Federation give this accident appropriate publicity to its members, with particular emphasis on the potential dangers of flying ultralight aircraft without undergoing proper training and achieving a safe flying standard.
2. It is recommended that the Australian Ultralight Federation consider the most appropriate type of helmets for ultralight operations and make recommendations to its members.