

**Aviation Safety Investigation Report
198803491**

Robinson R22 Beta

24 October 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: 198803491
Location: Caloundra QLD
Date: 24 October 1988
Highest Injury Level: Nil
Injuries:

Occurrence Type: Accident

Time: 1230

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

Aircraft Details: Robinson R22 Beta
Registration: VH-HIW
Serial Number: 706
Operation Type: Aerial Work
Damage Level: Substantial
Departure Point: Caloundra QLD
Departure Time: 1105
Destination: Caloundra QLD

Approved for Release: 11 April 1989

Circumstances:

The pilot undergoing the check flight had completed a helicopter instructor course about two months earlier and had not flown this helicopter type for nine years. He was being checked for future employment as a Grade 2 helicopter instructor. The early part of the flight was conducted in the training area where various types of circuit and approaches were carried out satisfactorily. On return to the aerodrome the instructor demonstrated an autorotation to touchdown. The pilot under check then conducted two autorotations to touchdown. The instructor reported that during the touchdown phase on the second landing the other pilot applied excessive collective control. He attempted to correct the situation but was physically unable to prevent the other pilot from raising the control. Rotor rpm decayed excessively and the tail boom was severed in the ensuing hard landing. The pilot under check was experienced on another type of helicopter requiring a different landing technique from this one. He was also not used to having another pilot making control inputs and did not give precedence to these inputs. The instructor had evidently made no verbal comment to the other pilot that he was applying corrective inputs to the controls.

Significant Factors:

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

1. The pilot under check lacked recent experience on type.
2. The instructor did not communicate his concerns or intentions during the flare before touchdown.
3. The instructor was unable to override the other pilot's control inputs.
4. Adequate rotor rpm was not maintained.

