Aviation Safety Investigation Report 198800122

Cessna 206U

27 May 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: 198800122 **Occurrence Type:** Accident
Location: Kununurra Airport WA
Date: 27 May 1988 **Time:** 745
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: Cessna 206U
Registration: VH-TXH
Serial Number: U20603032
Operation Type: Charter
Damage Level: Substantial
Departure Point: Kununurra WA
Departure Time: 0530
Destination: Ord River Station WA

Approved for Release: February 27th 1989

Circumstances:

During the approach to land at Ord River Station the Pilot in Command (PIC) discovered that throttle movement was restricted within the range 18 to 23 inches of manifold air pressure. After considering the various alternatives the PIC elected to return to Kununurra and attempt a landing. The PIC sought advice from the company Chief Pilot before attempting a landing. Following a practice circuit, to determine the minimum approach speed obtainable, the Chief Pilot instructed the PIC to repeat the circuit and to close the mixture at 300 to 400 feet on final approach. The PIC flew a slightly modified circuit, which involved a longer, flatter final approach and closed the mixture, as instructed, at 300 feet on final approach. Shortly after closing the mixture the PIC realised that the aircraft would not reach the runway and she attempted a landing in a grass area short of and to the left of the threshold. During the landing the aircraft collided with a ditch which had been hidden from the PIC's view by the grass. Movement of the throttle was restricted because a throttle linkage pin, which had been fitted incorrectly, was binding against a loose induction air box. The bolts holding the induction air box in place had not been secured correctly at the last servicing. Three of the four retaining bolts were found lying in the engine bay. The PIC was inexperienced in commercial operations and the Chief Pilot was known to exercise "positive" supervision over the company's operations.

Significant Factors:

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

1. Inadequate maintenance. An incorrectly fitted pin and inadequately secured bolts.

2. Restriction in the available movement of the throttle.

3. The delivery of the Chief Pilot's assistance as an instruction, which was in accordance with his normal personality, instead of as advice over-rode the PIC's natural caution.

4. The PIC's lack of experience prevented her from differentiating between information which should be obeyed and information which should be used as guidance.

5. Channelised attention when the PIC closed the mixture at 300 feet rather than when a landing was assured.

6. Hidden obstruction.

Reccomendations:

1. The CAA should develop an article, based on this accident, for publication in the Safety Digest which highlights the correct actions taken by the pilot, eg her decision to return to Kununurra, to seek advice from more experienced pilots and to carry out a practice circuit, and the factors to be taken into consideration before advice from external agencies is accepted. It should also look at how external advice should be presented to a pilot who is encountering difficulties.