Aviation Safety Investigation Report 198803480

Bell 206L-1

11 September 1988

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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 <u>www.atsb.gov.au</u>.

Occurrence Number: Location: Date: Highest Injury Level: Injuries:		198803480 Emerald QLD 11 September 1988 Nil			Occurrence Type: Accident Time: 1000	
0			Fatal	Serious	Minor	None
		Crew	0	0	1	1
		Ground	0	0	0	-
		Passenger	0	0	0	0
		Total	0	0	0	1
Aircraft Details:	Bell 20	5L-1				
Registration:	VH-MQA					
Serial Number:	45645					
Operation Type:	Private					
Damage Level:	Substantial					
Departure Point:	Emerald QLD					
Departure Time:	N/K					
Destination:	Emeral	1 QLD				

Approved for Release: November 1st 1988

Circumstances:

The pilot had just washed the helicopter, and carried out a circuit to dry the machine. At the completion of the circuit he intended to carry out a practice autorotation. The pilot reported that after turning onto final he noticed that the wind direction had altered so he decided to extend the final leg and selected a different touchdown point. As he flared the aircraft he noticed that the ground sloped and decided to apply some collective and touchdown on a flatter surface. The aircraft touched gently but the pilot reports that the main rotor RPM had decayed and a violent resonance occurred. The subsequent inspection of the tailboom found that the skin had been rippled near the forward end.

Significant Factors:

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

- 1. The pilot did not carry out a go-around when he realised his initial touchdown point was unsuitable.
- 2. He allowed the main rotor RPM to decay.