Aviation Safety Investigation Report 198501398

Cessna U206

4 May 1985

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: 198501398 **Occurrence Type:** Accident
Location: 4 km South of Meredith VIC
Date: 4 May 1985 **Time:** 1745
Highest Injury Level: Nil
Injuries:

	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: Cessna U206
Registration: VH-PQT
Serial Number:
Operation Type: Parachute Jumping
Damage Level: Substantial
Departure Point: Meredith VIC
Departure Time: 1730 (Aprx)
Destination: Meredith VIC

Approved for Release: 7th August, 1985

Circumstances:

The aircraft initially touched down about halfway along the strip, became airborne again, then touched down 50 metres before the end of the strip. The pilot applied power to go-around. However after reassessing the situation he closed the throttle and attempted to steer the aircraft through a gate. The nose wheel dug into the ground and the aircraft tilted forward onto the propeller and left wing. The propeller spinner struck the gate and the aircraft stopped. The approach had been conducted in conditions of reduced visibility as a result of cloud cover and impending last light. The pilot had misjudged the approach and had used a higher than normal airspeed. The lack of visual cues evidently caused the pilot to delay initiating a go-around while such a manoeuvre could still have been safely accomplished.